

# *Florida* **HEALTH NOTES**

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**PUBLIC HEALTH NURSING**

# Florida HEALTH NOTES

ESTABLISHED 1890

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## PUBLIC HEALTH NURSING

"Nursing service is needed to translate into practice almost every phase of public health. Child hygiene, maternity service, venereal disease and tuberculosis control, industrial hygiene and even home and community sanitation programs, are only a few of the services which, if they are to function effectively, must have the guidance and assistance of nurses.

"Although public health nursing originated because there was need for professional nursing care of the sick on a visit basis in the homes, some of our public health administrators have lost sight of that important public health nursing function. Prevention and cure of disease are two sides of the same problem. They are not two separate problems.

"From the beginning, public health nurses have been concerned with the total health situation of the family, including sickness, care, disease prevention, and health promotion. The whole public health profession, including hospital and sanatorium administrators, must share this same point of view if optimum health is to be obtained for all during the post war period."

THOMAS PARRAN, *Surgeon General,*  
*United States Public Health Service.*

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## PUBLIC HEALTH NURSING

by **RUTH E. METTINGER, R.N.**, *Director*

*Bureau of Public Health Nursing, Florida State Board of Health*

The public health nurse is an integral part of community life. She has made a large contribution in making possible a generalized health service to all classes of the population. Public health is a community responsibility; therefore, the citizens should be better informed about health conditions, the service the public health nurse renders, how these services should be used and the method of work the public health nurse employs.

Unfortunately, too few of the citizens are familiar with the health program. Of one thousand volunteers interviewed by the Civilian Relief Volunteer Defense Office in one large city, only fifty had ever heard of a public health nurse.

Forty years ago there were less than 500 public health nurses in the United States; at the present time there are approximately 20,000. There are still more than 1,000 counties in the United States uncovered by the service; and in the majority of the counties where the service is offered there are too few nurses to give the time and service which is desired and needed in a family situation. This is especially true in Florida where the service is mostly rural and such very large areas are to be covered.

Half a century ago the work of the public health nurse was confined to the nursing care of the sick in the home. Today additional responsibilities devolve upon her. She interprets the principles of healthful living necessary for the promotion of physical and emotional health and the prevention of disease. She must have the ability to understand the real situation which confronts the family, the ability to think and feel with the family, and resourcefulness in finding ways of improving conditions or bringing about changes that are essential to successful family health, securing as a result good service to the public.

With the return of the veterans wounded in mind and spirit, new situations will have to be met by the public health nurse. The demand for the service will increase rapidly, making it necessary to have three times the number of nurses now available.

Continued on page 15



Along with home calls, school visits, general follow-up work, and family counseling, a PHN is responsible for having all supplies shipshape and assists physicians during the many clinics held in her particular district. PHN Esther Spoelstra is shown preparing materials for one of Dr. Maryland Byrne Burns' Well Baby Conferences at which more than 60 Negro babies are checked every week. Ofttimes, as many as 20 small patients are turned away at this clinic because of insufficient time and personnel. (Staff photo)

*The pictures in this issue, which show high spots in the day of a public health nurse, were taken in Miami in cooperation with the Division of Public Health Nursing, Dade County Health Department. Featuring Dade County PHNs, however, does not imply that the activities and problems of the public health nurse are any different there than in other sections of the State, as nursing problems are pretty much the same wherever there are people.*



## THE VISITING NURSE

by **MABLE E. GROVER, R.N.**, *Executive Director*

*Duval County Visiting Nurse Association, Jacksonville, Florida*

The sparcity of community nursing services which include bedside nursing care is increasingly evident. This is strange, considering that public health nursing, started in this country not much more than 50 years ago, was first confined largely to bedside nursing care. Since, according to estimates, at least 80% of the ill do not go to hospitals, it is exceedingly important that every community give serious thought to facilities for the adequate care of the sick at home.

Public health nursing services are usually administered either by official agencies such as state, county, or city health departments or boards of education, or by a non-official agency such as the Visiting Nurse Association. The trend today is toward generalized health programs wherein all types of nursing services are provided to everyone in the community on a pay, part pay, or free basis.

In communities where official public health nursing agencies operate, a bedside nursing program can be included and should be encouraged as a part of that agency's responsibilities. If this cannot be arranged, a separate well-organized nursing service such as a Visiting Nurse Association should be set up.

The Visiting Nurse Association is a community nursing service developed through a representative citizen's committee, organized under a board of directors and employing registered graduate nurses who give part-time nursing care to anyone sick at home and under the care of a physician. The visiting nurse answers all calls but continues to give care only when there is a physician in attendance. In emergencies, first aid care, as recommended by the medical advisory committee of the county medical association, is given until the physician arrives.



This is the second visit PHN Monica Sullivan has made to this 18 year-old mother and seven weeks old Junior to check his weight and inspect a questionable skin rash (also being watched by the physician). The mother is an EMIC patient (Emergency Maternal and Infant Care, available to the wives of all servicemen in the four lower pay grades). By this time the mother is with her parents in Atlanta, while her husband is "en route over there." Postpartum visits are important MUSTS in the day of a PHN, and each has more than her share these days.

*(Staff photo)*

During the post-partum period, if the mother has been delivered at home, the nurse visits daily or every other day for the first eight or ten days, and then makes weekly supervisory visits until the baby is a month or six weeks old. After that time supervision is continued either by the Visiting Nurse Association or by the public health nurse, depending on the cooperative plan worked out by community agencies.

When the mother has been delivered at the hospital, the nurse makes home visits soon after the mother returns home. Here advice is given on proper care of the infant and the mother is relieved for a few days when the nurse bathes the baby and makes up the formula, if prescribed, until the mother is strong enough to resume full responsibility. This service is particularly important today when mothers often return from hospitals on the fourth or fifth day after delivery.

Visiting nurses not only give nursing care but teach and demonstrate to family members what should be done for the patients during their absence. The nurse must possess initiative, resourcefulness and up-to-date scientific knowledge. Considerable time is given to promoting the health of the entire family during these calls. When problems arise which are beyond her province, the nurse puts the family in touch with the community agency equipped to care for the condition.

The visiting nurse makes home visits between the hours of 8:30 a. m. and 5:00 p. m., except on Sundays and holidays when she visits only those patients who are seriously ill or in need of special treatments which cannot be given by family members. In some communities an evening service is also provided. As often as possible the very ill patients are visited first but visits are also planned for the day so as to reduce travel time to a minimum and to make the service available to the greatest number.

The charge for a visit varies in different communities but is based on the actual cost per visit. Adjustments are made by the nurse for those unable to pay the full fee. Free service is given to all unable to pay. Fees collected are used by the organization for the further development of the service. Basic costs of the organization are provided by Community Chest funds.

At present the Duval County Visiting Nurse Association is the only one in operation in Florida. Preparations are being made to develop these services in other communities. Pensacola expects to begin a program in January.

## A DAY WITH A PHN

by **ELIZABETH P. OLSON, R.N.**, *Staff Nurse,  
Dade County Health Department, Miami, Florida*

December 1, 1944

Dear Janet:

The life of a public health nurse, which you asked me to describe, my just-about-grown-up little sister, is a busy one, indeed, but any good work is busy work and what a satisfaction it is to be busy where you can see and know you are really needed! To give you some idea of the work, let me tell you what I did today.

When the alarm clock rang at 7:00 this morning, I felt like throwing it out of the window and grabbing another forty winks, but after a good breakfast my spirits perked up considerably, and the day got off to a good start.

The first call on the book was at the two-by-four unpainted shack of Mary McLear, who had just given birth to a strapping young-un and needed some advice on nursing, diet, and diapering. Since the temperatures all around were quite normal, and questions and answers taken care of, I scurried off to one of my five schools for the weekly routine visits—no, I take it back, there is no such thing as a routine visit in public health work, as even the least of our problems is far different from the next.

A bit of excitement was brewing in the fifth grade, with a full-blown case of mumps. Added to that, a generous mixture of colds, itches, and tummy-aches kept my hands full for a couple of hours. But there was still time to look in on the first graders to check their vaccination scars and also discuss the health program briefly with the principal as a reminder to both of us.

After visiting the home of little fifth grader mumpy midge and outlining his care to his mother, I felt a strong urge to obey lunch call. The school cafeteria offers an excellent hot lunch, and the third graders at our table had great sport following suit in picking a wholesome meal with plenty of "vitermins." I sat right next to little Mary Lou McLear, by the way, who just pumped me with questions when she learned



One of Miami's large trailer cities is located in PHN Rose Carney's district, and here she is talking with one of the tenants, a prenatal case who promises "to make arrangements at the hospital tomorrow, sure." A PHN advises expectant mothers on layettes, diet, exercise, stresses importance of plenty of rest and fresh air.

(Staff photo)

Cooperative planning and coordinated action on the part of all community health agencies are essential for better nursing care and better health for everyone. Each community must study its total resources and make every effort to use most effectively the facilities available.

The home nursing service includes the care of the acutely ill, of convalescents who have returned from the hospital but still need special treatment, and of the aged or chronically ill who may need nursing care daily, weekly, or at irregular intervals.

Besides bedside care, the visiting nurse is responsible for the home nursing supervision of hundreds of mothers during the entire maternity cycle. She visits prenatal patients according to their individual needs and in cooperation with private or clinic physicians. She helps the mother to prepare her home for the new baby.





Nursery schools for children of working mothers fall in the category of war emergency, and are therefore sort of "extra curricular" for those PHNs who have them in their districts. Here, PHN Mrs. Olive Gause is lending a hand to the short-handed staff in getting the children ready for lunch. She observes the children closely for signs of communicable diseases—checks eyes, throats, ears and watches for symptoms of malnutrition. (Staff photo)

"Open your mouth and say ahh." And this little man, one of Miami's public school youngsters, takes it in his stride. Last time PHN Rose Carney looked at Bobby's throat it was wild and threatening. But a visit to the family physician, plus a few days at home, has put him in first class condition. Miss Carney admits a weakness for visiting the schools in her district, but says that "first things must come first," and that schools must be taken in order of their importance for the day.

(Staff photo)



I'd visited her mother and new baby brother earlier in the morning. The way she bragged about that baby to her classmates made me feel mighty proud I'd helped in that home!

Time goes so fast when you're out in the field with plans running through your head for mothers' classes the next day, and the doctor's examination of school kiddies com-

First stop of the morning for PHN Ruth Seals was a visit to a prenatal case whose blood test had been reported positive. This patient "can't believe my eyes," and promised to be on hand for the VD clinic Friday night, provided Nurse Seals is there to "show me what to do in that strange place." Patients often build up a child-like trust in their public health nurses.

(Staff photo)



One of PHN Monica Sullivan's most important calls of the day was to see why members of this home weren't reporting more regularly to the tuberculosis clinic for routine examinations. The girl with whom she is talking is 18 years old—married, and has two children. Her husband is overseas. She and her children live with her mother, stepfather and three small stepbrothers and sisters. The mother, father and one child are current but lax patients at the clinic. When urged to have x-rays of herself and children at the clinic, she thought she would "sometime, when I get around to it." It thus becomes one of Miss Sullivan's challenges to see that this girl is x-rayed and given some semblance of protection, in spite of herself. Among a hundred attributes, tact and persuasion are two necessary ones in the make-up of a public health nurse.

(Staff photo)

ing up next week. It's slow steady work to teach people the value of prevention as well as cure.

And this afternoon flew twice as fast, with a visit to an arly case of tuberculosis, arranging for his family and close contacts to have x-rays and to prepare for his rehabilitation

when he comes home from the hospital. If only people all over would realize the health and well-being saved by early diagnosis, isolation and treatment of any of these contagious diseases!

Right in the next block I had a nice visit with a very young expectant mother, planning through the months of baby clothes, crib, wholesome diet and healthful living. She hadn't realized the importance of securing medical advice and examination, which is in reach of nearly all prenatal cases now-a-days.

By the time I had turned my records and reports into the main office and planned things for the next day, I was ready for a good nourishing meal myself. Of course, tomorrow will bring an entirely new set of problems and families to call on, but the variety is spicy.

You can see from this, I think, a little of what our generalized program means, and believe me, I'm sold on it! Although there are many different families to work with it isn't long until you find things tie together most helpfully when you're working with the whole family as a unit. I think I can do a much better job with the school children because I know so much more about their total home situations and their troubles. First graders are anything but "new children" to me! Rather than helping a mother with just one of her worries, I know most of the ins and outs of all the family health problems. I just know that home visitation is more helpful because it's better rounded. Our generalized program is certainly reaping more effective results.

That's the life of a public health nurse—and believe me, it takes all the psychology, understanding and foresight you can muster, but the satisfaction in our work pays big returns!

Give my love to the folks,

P. S.

Betty.

Forgot to tell you of the P.T.A. meeting and my enviable (?) position as guest speaker! However, the audience was so good about asking questions we turned it into a discussion rather than a lecture.

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**"YOUR CAREER—WILL IT BE PUBLIC HEALTH NURSING?"** A leaflet presenting the possibilities of public health nursing as a vocation. Copies are free from the National Organization for Public Health Nursing, 1790 Broadway, New York 19, N. Y.

## GUIDING THE MIDWIVES

by **MARTHA STETSON, R.N.**, *Supervising Nurse,  
Pinellas County Health Unit, St. Petersburg, Florida*

No one knows just how long midwifery has been in existence. Twenty-five years ago there were 3,330 midwives in Florida. Today there are only about 500. Women are not encouraged to take up midwifery unless the need becomes too great in certain areas, in which case they are very carefully selected.

The State Board of Health, however, is employing certified nurse-midwives (registered nurses who have had special training in obstetrics) as rapidly as possible. These are placed where the need is greatest. At present there are only seven certified nurse-midwives in the state but the number will undoubtedly be increased as nurses become available for this special training.

In Pinellas County, one of our largest counties, the number of midwives has been reduced to eight. Here, the public health nurses conduct monthly meetings with the midwives in the fully equipped classroom which was built and furnished by the St. Petersburg Pilot Club. This room also is used for Negro clinics. Everything needed for a delivery, supplies for the midwife, mother and baby are on display. Each midwife keeps her two bags and two obstetrical packs on hand and she is supervised to see that the proper equipment and bags are used.

During the monthly meetings, part of the time is used for instruction and part for record work. All patients of midwives are registered with the health unit, where records are kept of the date each case was accepted, the date of the first clinic visit, of the delivery, and of the post-partum examination. These records are available for all midwives to see at any time; this prevents them from taking each other's cases.

Before a midwife may accept them as cases, all patients must have a physical examination by either a private physician or at the health department clinic. Midwives accompany their patients to the clinic for examinations by the physician and are responsible for their regular attendance. During clinic visits, midwives show their patients demonstration material and advise them concerning their needs.

ment signed by the attending physician indicating that it is still satisfactory for the midwife to proceed with the case. If during delivery any complications occur, the midwife is instructed to contact a physician or the health department for advice immediately. Most are exceptionally conscientious about this. Physicians are called when repair work is necessary.

Patients of midwives, from the time they are registered until the post-partum period is completed, are under the supervision of the county health department. The midwives welcome the supervision and they feel they are a part of the health unit. Public health nurses do much of this supervisory work. They make home visits and carry cases that are warranted. So long as these needs cannot be met more adequately in other ways, the supervision of midwives is invaluable work.

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**PUBLIC HEALTH NURSING, Continued from page 3**

It is necessary for the nurse wishing to enter the field of public health to have not only basic nursing preparation from an accredited training school, but also to have post graduate study at one of the universities offering the approved course in Public Health Nursing. It is also an accepted principle that nurses wishing to enter other specialized fields, such as teaching of nursing and the administration of nursing education, require instruction and experience in addition to the basic preparation.

Every community and every organization wishes to employ the best prepared staff possible. The citizens of every community should take an active interest in this service. It is important, also, that the organization and administration of the service make it possible for each member to contribute to the limit of her ability. Well-prepared nurses may fail to give the desired service if there is not back of them a sound, reasonable and understanding administration. A satisfactory method of working with other health and social agencies and well-defined responsibilities for each member of the staff form the background of strength upon which the nurse relies. Good administration is essential to good service.

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**"REWARD UNLIMITED"**

... Is a new 10 minute sound film dramatizing the great need for Cadet Nurses, with Spring Byington heading the cast. The General Extension Division Film Library, University of Florida, Gainesville, will loan the film to any organization in Florida.





The aged midwife on the left is retiring from active service—receiving an honorable discharge from the State Board of Health in recognition of nearly half a century of work in midwifery in Leon County. She is shown presenting her bag to her daughter who is a graduate nurse attached to the Leon County Health Department.

(Staff photo)

In-service-training for midwives is stressed throughout Florida by the State Board of Health. More modern methods which make the practice of midwifery easier and safer are being taught to midwives ranging from the young to the "granny" type in age. All midwives must work under the supervision of the county health officer. However, in counties where there are no organized health units, they function under the direction of the State Board of Health's nurse consultant. Leon County is outstanding in its advanced training program. Here, PHN Lilly Mae Chavis (certified midwife), Tallahassee, is demonstrating to her weekly class the technique of weighing a "brand new" baby.

(Staff photo)



Before a midwife may accept any case which is under the prenatal care of a private physician, she must present to the county health department, a statement signed by the attending physician that it is apparently safe for the midwife to deliver the patient. At the end of the eighth month of the patient's pregnancy, the midwife must present another state-

## MORE ABOUT —

**Public Health Nursing Services**

**The Number of PHN's Today**

**Their Qualifications**

**Administrative Abilities**

**The Future of Public Health Nursing**

in—Pearl McIver's "Public Health Nursing," Supplement No. 133 to the *Public Health Reports* available from the Superintendent of Documents, Washington, D. C., price ten cents.



# *Florida* **HEALTH NOTES**

PUBLISHED BY THE FLORIDA STATE BOARD OF HEALTH

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**VENEREAL DISEASE CONTROL**

# The State Board of Health

ESTABLISHED 1890

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# Florida HEALTH NOTES

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## SPEED V-DAY OVER V D

The venereal diseases exist in spite of the significant advances in the development of new drugs, new methods of treatment, in spite of the efforts of public-spirited communities; and in spite of the fact that by avoiding exposure to them, these diseases can be prevented altogether.

Yet, serious as the picture still is, important gains have been made on all fronts—medical, educational, moral, community action. Communities in many parts of the nation have conducted large-scale, persistent and effective campaigns against VD. Man-days in the armed forces lost through these diseases have been brought to an all-time low. There has been an almost complete crack-down on organized prostitution.

What is still lacking is not the *quality* of the effort made, but the *quantity*. The great need now is to step up the fight, to maintain and extend the gains through to victory and into the post-war world.





# VENEREAL DISEASE CONTROL IN FLORIDA 1944

by **R. F. SONDAG, Surgeon (R) U.S.P.H.S.**  
*Director, Bureau of Venereal Disease Control*

The past year has been a significant one in venereal disease control due to the many developments in the treatment of these diseases. At the beginning of the year, the vast majority of patients under treatment for venereal diseases were receiving this treatment in one of the clinics cooperating with the Florida State Board of Health. The Rapid Treatment Centers at Ocala and Wakulla were treating only females in the infectious stages of syphilis and gonorrhea, and the Rapid Treatment Center in Jacksonville was doing likewise for both males and females.

In the early part of the year, the Gulf Coast Medical Center, under the supervision of the U. S. Public Health Service, was established at Pensacola. This center accepted for treatment males and females, white and colored, with early infectious syphilis and gonorrhea. These Rapid Treatment Centers with a combined capacity of 650 beds were filled each month as the type of treatment then used required from two to twelve weeks in most cases, a few being able to complete the treatment in less than two weeks.

## **PENICILLIN**

During the month of April, the Bureau received its first allocation of penicillin and this new drug completely changed the treatment picture for syphilis and gonorrhea. With this new wonder drug, it was possible to cure gonorrhea in one or two days and syphilis in four to eight days. As a result of this drug, the average patient's stay in the hospital was reduced to less than fifteen days, the majority of patients only remaining on the average of three to five days. This permitted accommodations for many more patients and later in the year all Rapid Treatment Center facilities were made available to both male and female, white and colored patients.

With such a rapid turnover, the hospitals may now accommodate approximately 1,000 patients per month for

penicillin therapy. The rapid patient turnover has obviated the necessity for continuing the Wakulla Rapid Treatment Center, since the centers at Pensacola and Jacksonville are geographically more advantageous to the counties served; therefore, the Wakulla Rapid Treatment Center ceased operations on December 31, 1944, and the Florida State Board of Health took over the maintenance and operation of the Gulf Coast Medical Center at Pensacola.

Since penicillin was under strict supervision of the War Production Board and its allocation and usage limited, this drug could only be used on selected cases of syphilis and gonorrhea until the latter part of the year when the restrictions were eased somewhat to permit the use of this powerful weapon on a broader scale. The Rapid Treatment Centers now accept all patients with early syphilis and all types of gonorrhea. Permission to use penicillin on a broader scale caused an influx of patients into the Rapid Treatment Centers before they were declared ineligible for this type of treatment.

Up to 1944 the treatment of syphilis was a long procedure and most patients were reluctant to abide by the weekly schedules which were necessary to effect a cure; therefore, the introduction of penicillin was a welcome addition to the person concerned with venereal disease control. It is now possible to be cured in such a short time that everyone with a venereal disease is most desirous of submitting to this form of treatment. Since penicillin is still under the jurisdiction of the War Production Board, and its allocation still limited, this Bureau must necessarily select the type of cases acceptable for admission to the Rapid Treatment Centers. Penicillin, no doubt, will become more generally available in the near future, thus permitting wider use of this drug in all types of venereal diseases.

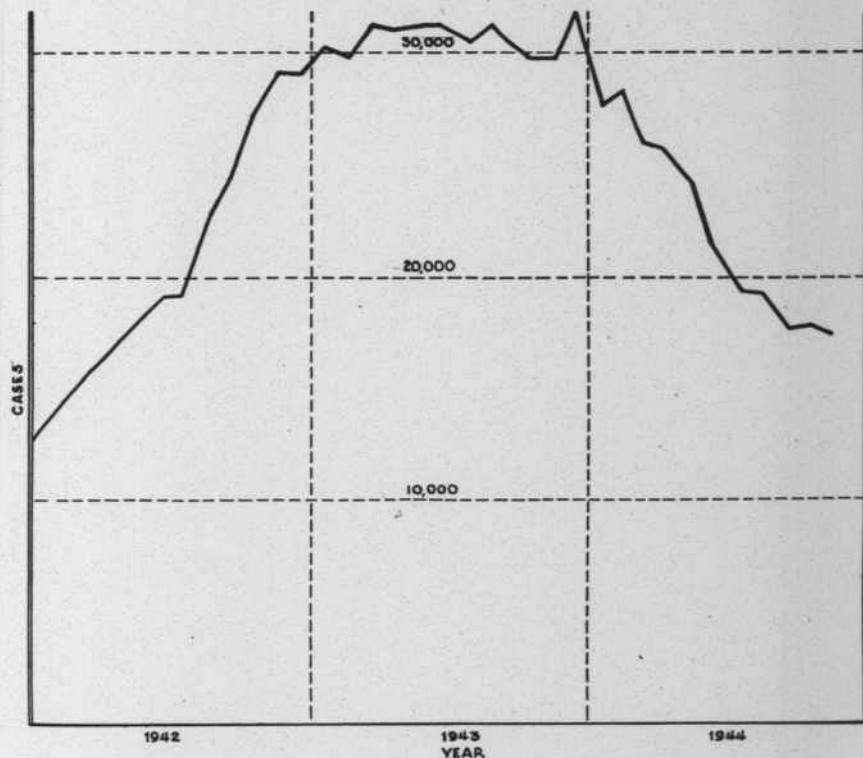
### FEWER CASES

With the introduction of penicillin and other forms of intensive treatment in the Rapid Treatment Centers, the clinic patient loads in the State have been considerably reduced. Elsewhere in this issue one will find numerous charts and graphs showing the activities of the Bureau during the year 1944. Since the VD Program in the State of Florida has been conducted rather intensively for the past three or four years, it is only reasonable to assume that even with the long drawn out treatment, patients on this type of therapy would also eventually be cured of their disease. Actually, a large number of cases were discharged from the clinics throughout the year after hav-

ing completed the required amount of treatment. This, in addition to the fact that fewer new cases were reported in 1944 than during the previous two years, has decreased the clinic population throughout the State to a level comparable to the case load in the latter part of 1942 when the program was just gaining momentum.

A review of the charts presented herein will reveal that during 1942 and 1943 over 30,000 new cases of syphilis

GRAPH 1.—NUMBER OF CASES OF VENEREAL DISEASE UNDER TREATMENT IN CLINICS, BY MONTH 1942-44.



were reported each year, while for 1944 less than 20,000 cases were reported. This may be an indication that the venereal disease problem in Florida is considerably less severe due to the intensive program which has been carried out for the past few years. Those concerned with this problem should like to interpret these figures as such, but one never knows when there might be a sharp increase in the opposite direction.

TABLE 1.—NUMBER OF SYPHILIS CASES REPORTED IN FLORIDA BY PRIVATE PHYSICIANS AND CLINICS, NUMBER AND PERCENT PRIMARY AND SECONDARY BY YEAR 1941-1944.\*

Year	#Total Cases of Syphilis Reported	Number Reported By Clinics	Number Reported By Private Physicians	Primary and Secondary Cases Reported		Per Cent Primary and Secondary Cases Reported	
				By Clinics	By Private Physicians	By Clinics	By Private Physicians
1941	21,258	14,267	6,991	1,523	1,874	44.8	55.2
1942	30,104	22,000	8,104	1,582	2,708	36.9	63.1
1943	33,540	27,534	6,006	2,235	1,422	61.1	38.9
1944	19,087	15,524	3,563	1,849	532	77.7	22.3

(\*Out of State Cases Excluded)

## LESSENERED TRANSMISSION

It is the honest belief of the Bureau that the Rapid Treatment Centers and their intensive therapy schedules have played a major role in reducing the reservoir of infected individuals in this State. It is a medical fact that in order to control an epidemic, the infectious individuals must be removed from contact with non-infected individuals. Such a role is played by the Rapid Treatment Centers. Thousands of infectious patients were isolated and treated until cured in the Rapid Treatment Centers, thereby eliminating the possibility of their further spreading the disease to non-infected individuals. In addition, infectious persons have been interviewed in an effort to ascertain the origin of their infection and also those whom they themselves may have exposed. As far as possible all such contacts were visited and an effort made to determine if an infection existed. Those individuals found to be infected were in turn encouraged to report to a private physician, to a Rapid Treatment Center in this State or to some other state when the contact had moved out of jurisdiction.

TABLE 2.—NUMBER OF VENEREAL DISEASE CASES REPORTED IN FLORIDA, BY DISEASE AND YEAR 1940-1944.\*

Year	Syphilis	Gonorrhea	Chancroid	Granuloma Inguinale	Lymphopathia Venereum
1940	19,877	1,824	110	21	21
1941	21,258	3,048	154	76	49
1942	30,104	10,165	453	135	124
1943	33,540	16,295	844	251	254
1944	19,087	14,351	535	217	248

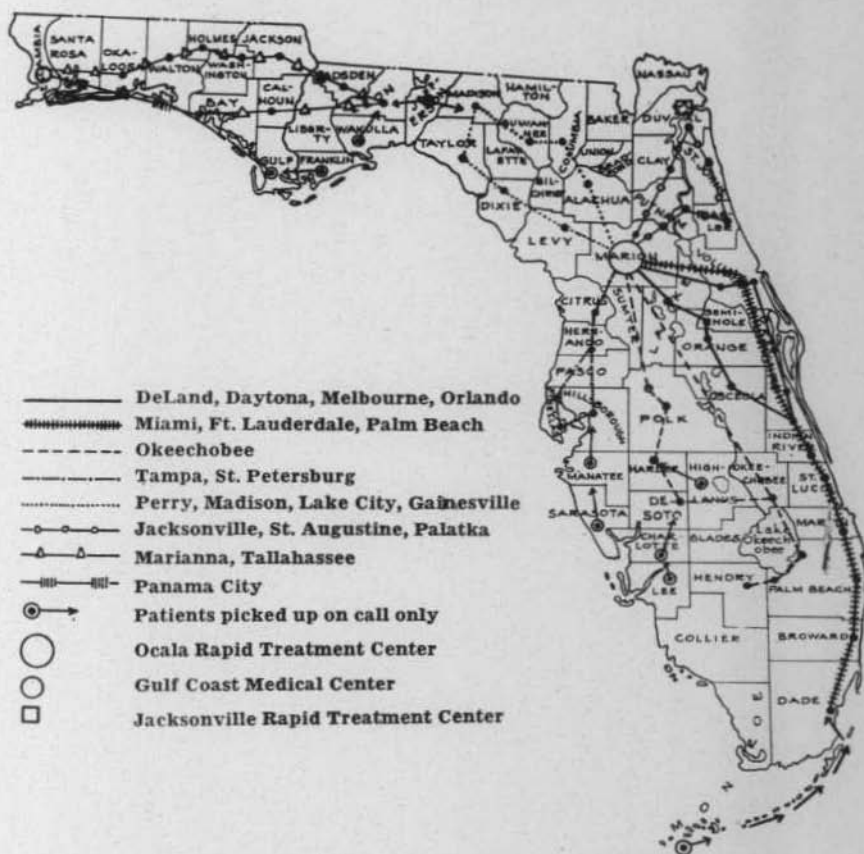
(\*Out of State Cases Excluded.)



## TRANSPORTATION

One of the major obstacles throughout the year was the problem of transportation. Recently, the Bureau was fortunate to be able to purchase from the Army Medical Corps four ambulance type carry-alls and several station wagons, which are now being used to aid in the transportation of patients to the Rapid Treatment Centers. On this page there is a map showing the various routes which have been established to pick up patients for transportation to the Rapid Treatment Centers. Since the establishment of these routes the influx of patients at the Rapid Treatment Centers has been spectacular.

MAP 1.—STATION-WAGON ROUTES FOR TRANSPORTING PATIENTS TO RAPID TREATMENT CENTERS



## WORK PROGRAM

When Rapid Treatment Centers were first instituted in the State the majority of patients, scheduled to remain not less than ten weeks, were not confined to bed and thus presented the problem of organizing activities to consume their free hours. This resulted in a work program which afforded patients an opportunity to earn money while under treatment and was of material assistance in the operation of the Center. Since the advent of penicillin, such a program is impossible, as the majority of patients are no longer ambulatory and the stay in the hospital is too brief to profitably utilize patient labor. Rapid Treatment Centers are now conducted and operated, therefore, as any well-organized hospital. Patients are admitted as bed patients and treated in bed until they have received the calculated dosage of penicillin which will effect a cure for their disease, after which they are released and instructed to report at specific intervals to their private physician or health department for follow-up blood tests and clinical observations.

Private physicians and health directors are cordially invited to visit these Rapid Treatment Centers that they may personally inspect the facilities. Rapid Treatment Centers in the State have been visited by many nationally famous physicians and professional workers. The register at the Jacksonville Center alone lists the names of some outstanding authorities who have inspected the Center and consider it one of the finest in the country.

The Florida State Board of Health has been told repeatedly by persons in authority that from a practical and statistical standpoint the Rapid Treatment Centers operating here more nearly approach the ideal than those operating in any other state in the country. Florida may be justly proud of the part it has played in the national program to eliminate venereal diseases.

TABLE 3.—MONTHLY AVERAGE OF PATIENTS UNDER TREATMENT IN CLINICS IN FLORIDA, BY YEAR 1940-1944.

Year	† Monthly Average of Patients Under Treatment In Clinics
1940	8,843
1941	12,600
1942	20,131
1943	30,655
1944	22,206

## REGULAR CLINICS

Thus far this discussion has dealt entirely with Rapid Treatment Centers and little mention has been made of the large number of health departments and clinics which were established prior to the inception of a rapid treatment program. It is needless to state that without the diagnostic facilities in the clinics throughout the State, the Rapid Treatment Centers would be unable to justify their existence. Many clinics have decreased their case loads to an absolute minimum by referring all infectious cases to the Rapid Treatment Centers; whereas, previously these patients would have been treated over a long period of time in the clinics. Health officers and clinicians now have a greater opportunity to search for early infectious cases of venereal diseases, whereas formerly the majority of their time was consumed in treating the large number under standard therapy. This enables them to devote more of their time to public health administration and other health problems.

TABLE 4.—NUMBER OF VENEREAL DISEASE CASES\* UNDER TREATMENT IN CLINICS BY MONTH, 1942-1944.

Month	YEAR		
	1942	1943	1944
January	13,393	30,218	27,943
February	14,317	29,956	28,631
March	15,715	31,311	26,117
April	16,912	31,156	25,611
May	18,186	31,255	24,475
June	19,248	31,296	21,538
July	19,461	30,710	19,823
August	22,600	31,412	19,864
September	24,633	30,472	18,287
October	27,743	30,008	18,303
November	29,236	30,076	17,943
December	29,227	32,285	**18,000
TOTAL	250,671	370,105	266,535

\*Includes Rapid Treatment Centers

\*\*Estimated.

## EDUCATIONAL CAMPAIGN

Late in 1943 plans were formulated to conduct a venereal disease educational campaign, statewide in scope. The Honorable Spessard L. Holland, Governor of Florida, proclaimed the month of January, 1944, as Venereal Disease Control Month and with his official proclamation the educational campaign was placed in motion. Wartime health committees were organized in practically every community in the State and through the effort of these Committees, advertising space in many leading

newspapers called attention to venereal disease prevention; radio programs and window displays were arranged; and posters, pamphlets, leaflets, and many other educational materials were distributed for community consumption. Although the campaign was launched primarily for the month of January, the enthusiastic support of the wartime health committees carried the campaign through the month of February, and in many localities these committees are still active. Plans have been made to evaluate the results of this campaign at a later date and the statistics will be presented in the next venereal disease number of *Health Notes*.

It is generally conceded that education and rapid treatment are the two most important factors aiding in the reduction of venereal diseases. As mentioned previously it is the consensus of this Bureau that Rapid Treatment Centers have been instrumental in reducing the reservoir of infection; however, it would be erroneous to overlook the part played by education and the effects this intensive campaign had upon the problem in Florida.

TABLE 5.—NUMBER OF PATIENTS, BY RACE, RELEASED FROM FLORIDA RAPID TREATMENT CENTERS.\*\*

Listed according to counties committing them to the centers.  
(March 1943 through December 31, 1944.)

County	White	Colored	Total	County	White	Colored	Total	County	White	Colored	Total
Alachua	9	16	25	Lafayette	1	1	2	St. Lucie	27	27	54
Baker	3	0	3	Taylor	46	39	85	*Santa Rosa	8	1	9
*Bay	131	125	256	Lake	22	15	37	Seminole	32	37	69
Bradford	53	12	65	Lee	45	41	86	Sumter	5	2	7
Brevard	14	17	31	*Leon	141	194	335	Suwannee	5	2	7
Broward	15	12	27	Levy	2	6	8	Volusia	57	32	89
Calhoun	2	0	2	Liberty	0	0	0	Wakulla	6	1	7
Citrus	6	4	10	Madison	2	11	13	*Washington	2	4	6
Clay	21	10	31	Manatee	24	28	52	Okeechobee	36	6	42
Columbia	13	18	31	Marion	47	49	96	Dixie	9	1	10
Dade	133	58	191	Monroe	23	17	40	Hardee	10	0	10
DeSoto	4	7	11	Nassau	0	5	5	Sarasota	26	36	62
Duval	972	1129	2101	*Okaloosa	13	2	15	Collier	0	0	0
*Escambia	189	138	327	Orange	128	140	268	Gilchrist	0	0	0
Franklin	29	16	45	Osceola	4	0	4	Indian River	5	25	30
*Gadsden	11	30	41	*Palm Beach	29	102	131	*Walton	5	2	7
Hamilton	3	1	4	Pasco	5	2	7	Flagler	33	58	91
Hernando	0	1	1	Pinellas	50	35	85	Charlotte	24	4	28
*Holmes	2	0	2	Polk	61	61	122	Glades	2	1	3
*Jackson	86	39	125	Putnam	12	12	24	Highlands	15	22	37
Jefferson	10	7	17	St. Johns	32	40	72	Union	5	1	6
Hendry	2	10	12	*Gulf	8	17	25	Unknown	14	16	30
Martin	0	0	0	*Hillsboro	176	174	350				
Total								2905/2919/5824			

\*Does Not Include Patients Sent to Gulf Coast Medical Center.

\*\*Jacksonville, Ocala, Wakulla.

TABLE 6.—AGE DISTRIBUTION, BY RACE AND SEX OF 5824 PATIENTS RELEASED FROM RAPID TREATMENT CENTERS.\*

	White		Colored		Total	
	Male	Female	Male	Female	Male	Female
0-9	7	20	21	32	28	52
10-14	5	39	14	75	19	114
15-19	62	791	157	974	219	1765
20-24	149	856	188	740	337	1596
25-29	129	320	87	272	216	592
30-34	91	182	59	120	150	302
35	109	139	50	122	159	261
Unknown	0	6	2	6	2	12
All Ages	552	2353	578	2341	1130	4694

\*Includes Patients Released from Jacksonville, Ocala, and Wakulla Rapid Treatment Centers from Their Opening Date Through December 31, 1944. Total 5824.

## THE CHANGING PICTURE

Due to the tremendous venereal disease problem in the State of Florida, clinics were established in practically every county in the State. It was the purpose of these clinics to place under treatment the large number of selectees who had been rejected for military service and other individuals infected with venereal diseases who failed to adhere to regular treatment with private physicians.

The most important phase of the Venereal Disease Control Program was the case-holding program; i.e. keeping patients under treatment until they were cured. With the advent of the intensive methods of treatment, especially penicillin, this phase of the program is relatively unimportant. Many individuals now receive all treatment within a few days and are only required to report for subsequent periodic examinations to determine whether additional treatment is necessary. As penicillin becomes more generally available the clinics will play a less important role in treatment, since many patients will find it more convenient to report to private physicians for penicillin therapy.

Within the next year we shall probably see again many changes in the control of venereal diseases, with many of the smaller clinics closing their doors and the larger ones playing a greater role in diagnosis. As in the past, but more so in the future, the burden of controlling venereal diseases will rest upon the private physicians' shoulders, but regardless of the source of treatment, the importance of education, case-finding and adequate treatment can not be over-emphasized.



TABLE 7.—DISEASE AND DIAGNOSIS, BY RACE, OF 5824 PATIENTS RELEASED FROM RAPID TREATMENT CENTERS\*

Disease	White	Colored	Total
Syphilis			
None	1973	698	2671
Primary	83	122	205
Secondary	175	473	648
Early Latent	482	1374	1856
Late Latent	53	131	184
Cardiovascular	0	3	3
Central Nervous System	109	53	162
Other Late	2	2	4
Congenital	28	63	91
Gonorrhea			
None	863	1526	2389
All Types	2042	1393	3435
Other V.D.			
None	2897	2739	5636
Chancroid	6	72	78
Granuloma Inguinale	0	30	30
Lymphopathia venereum	1	52	53
More Than One Oth. V.D.	1	26	27

\*Jacksonville, Ocala, and Wakulla.

TABLE 8.—COMBINATION OF DIAGNOSES, BY RACE, OF 5824 PATIENTS RELEASED FROM RAPID TREATMENT CENTERS.\*

Diagnosis Combination	White	Colored	Total
Syphilis Alone	591	1295	1886
Gonorrhea Alone	1697	525	2222
Other V.D. Alone	1	32	33
Syphilis and Gonorrhea	340	803	1143
Syphilis and Other V.D.	2	82	84
Gonorrhea and Other V.D.	3	23	26
Syphilis and Gonorrhea and Other V.D.	2	43	45
No Venereal Disease	269	116	385

\*Jacksonville, Ocala, and Wakulla.

TABLE 9.—TOTAL NUMBER OF CASES TREATED AT JACKSONVILLE, PENSACOLA, OCALA AND WAKULLA RAPID TREATMENT CENTERS WITH NUMBER OF PROBABLE REINFECTIONS AND RELAPSES BY DISEASE SINCE OPENING OF CENTERS THROUGH DECEMBER 31, 1944.

	Syphilis			Gonorrhea		
	Total	Probable Reinfections	Probable Relapses	Total	Probable Reinfections	Probable Relapses
White Males	311	0	7	490	30	26
White Females	657	0	20	1,901	163	14
Colored Males	651	2	35	242	11	3
Col. Females	2,150	4	50	1,691	98	19
Total	3,769	6	112	4,324	302	62

TABLE 10.—NUMBER OF CASES OF SYPHILIS AND GONORRHEA REPORTED  
BY COUNTY, 1940-1944.

	1940		1941		1942		1943		1944	
County	Syp.	Gon.	Syp.	Gon.	Syp.	Gon.	Syp.	Gon.	Syp.	Gon.
Alachua	424	12	378	19	965	105	784	118	348	65
Baker	79	2	118	6	76	20	45	10	31	25
Bay	219	25	241	34	412	255	553	422	437	454
Bradford	15	2	284	19	182	97	199	86	193	97
Brevard	120	3	122	6	168	2	419	91	73	33
Broward	630	5	797	54	773	110	742	231	479	258
Calhoun	1	0	1	0	26	2	48	5	9	1
Charlotte	23	0	29	3	170	8	65	33	15	17
Citrus	9	0	20	10	17	0	170	11	13	7
Clay Ex.	26	16	142	19	62	61	108	48	155	66
Camp Blanding			176	899	329	1478	316	1875	69	91
Collier	24	1	58	2	190	1	35	14	23	3
Columbia Ex.	103	10	84	10	59	8	714	24	88	31
Government Hospital							69	2	17	0
Dade	3051	475	3228	485	4229	522	4459	1349	2588	2016
Desoto	53	1	68	1	264	14	166	47	53	50
Dixie	77	1	18	0	74	1	215	0	14	5
Duval	2919	458	2973	419	3516	2115	6214	3032	3909	1826
Naval Air Base			27	93	31	428	36	503	43	529
Escambia	962	241	765	260	661	514	792	1127	812	1487
Flagler	25	5	81	5	79	11	94	8	108	55
Franklin	166	5	117	2	96	30	117	158	142	675
Gadsden Ex.	408	13	259	11	199	56	299	40	120	53
State Hospital	155	0	231	0	172	0	183	1	159	0
Gilchrist	0	0	99	1	42	0	4	1	1	0
Glades	43	1	174	5	110	7	18	8	32	6
Gulf	79	0	252	8	148	16	143	13	84	13
Hamilton	268	6	223	18	77	50	3	0	3	6
Hardee	49	1	34	0	95	17	36	5	34	10
Hendry	75	2	3	0	205	6	181	57	135	24
Hernando	35	0	20	0	53	0	142	2	9	5
Highlands	158	1	211	3	344	35	299	260	183	280
Hillsborough	2225	224	1827	221	2437	803	2920	1430	1417	1815
Holmes	23	3	6	0	18	1	51	0	51	14
Indian River	76	11	47	2	210	11	279	16	68	22
Jackson	671	11	342	30	237	109	211	133	113	164
Jefferson	63	2	112	0	432	42	201	64	78	47
Lafayette	3	0	4	0	7	1	14	0	4	1
Lake	473	9	382	8	611	97	380	95	201	96
Lee	82	2	62	1	650	108	286	39	149	41
Leon	527	13	438	50	659	1111	450	687	359	1128
Levy	36	2	679	1	301	15	152	62	10	3
Liberty	2	0	1	0	4	0	7	1	0	1
Madison	62	1	84	0	235	13	476	38	16	4
Manatee	456	0	175	3	503	35	218	187	178	84
Marion	177	9	262	6	359	27	1026	77	263	111
Martin	15	0	47	0	66	2	95	8	7	0
Monroe	38	32	38	24	147	80	308	171	142	220
Nassau	321	19	246	9	309	59	201	126	114	102
Okaloosa	19	0	4	14	140	24	171	248	61	224
Okeechobee	5	0	13	0	2	2	72	0	36	12
Orange Ex.	817	35	791	133	1023	629	850	846	580	313
Fla. T. B. Sanat.							2	1	2	0
Osceola	87	1	48	6	132	3	113	9	6	4
Palm Beach	1024	20	1479	41	1245	258	1274	335	2324	353
Pasco	71	4	66	0	114	2	175	4	55	3
Pinellas	441	60	1087	38	1111	277	927	596	370	319
Polk	917	9	421	2	690	34	1135	245	526	161
Putnam	106	8	45	2	401	6	320	39	82	37
Saint Johns	69	2	59	0	264	10	213	36	137	44
Saint Lucie	49	0	229	2	127	14	339	105	165	42
Santa Rosa	5	0	81	4	58	27	55	18	33	88
Sarasota	263	17	233	14	570	83	181	46	139	53
Seminole	207	0	215	6	1169	104	589	210	335	197
Sumter	26	0	43	1	227	14	190	165	85	6
Suwannee	24	0	55	4	259	9	377	10	9	4
Taylor	132	19	132	18	301	75	127	58	62	110
Union	9	8	4	4	24	1	20	1	11	7
State Prison							238	5	89	2
Volusia	108	10	129	8	944	83	680	260	310	186
Wakulla	35	1	94	0	85	15	111	290	16	21
Walton	14	1	43	4	164	12	46	45	58	69
Washington	3	5	2	0	45	0	141	22	47	55
Quarantine Hospitals							271	616		

GRAND TOTAL 19877 1824 21258 3048 30104 10165 33540 16925 19087 14351  
(Out of State Cases Excluded)

TABLE 11.—DISTRIBUTION OF DRUGS AS TO SOURCE AND KIND FURNISHED BY DIVISION FOR 1942-43-44.

DRUGS	DISTRIBUTED TO PRIVATE PHYSICIANS			DISTRIBUTED TO CLINICS, HOSPITALS & OTHERS			TOTAL DISTRIBUTED		
	1942	1943	1944	1942	1943	1944	1942	1943	1944
Mapharsen	33,920	54,877	36,270	336,310	536,510	398,820	370,230	591,387	435,090
Neoarsphenamine (In doses)	19,122	9,492	3,260	27,080	31,000	9,095	46,202	40,492	12,355
Sulfarsphenamine (In doses)	365	370	155	1,760	3,640	2,760	2,125	4,010	2,915
Tryparsamide (In doses)	150	500	940	5,700	9,190	10,550	5,850	9,690	11,490
Bismuth (In cc)	57,150	77,260	37,470	546,120	743,430	517,720	603,270	820,690	555,190
Sulfathiazole (In grams)	3,300	21,500	4,000	539,700	588,000	1,055,000	543,000	609,500	1,059,000
Distilled Water (In cc)	553,600	552,200	318,600	2,181,500	3,083,300	3,048,900	2,735,100	3,635,500	3,367,500
Penicillin (In Oxford Units)	0	0	0	0	0	1,092,000,000	0	0	1,092,000,000

TABLE 12.—SEROLOGIC TESTS FOR SYPHILIS AND MICROSCOPIC EXAMINATIONS  
FOR GONORRHEA—FLORIDA STATE LABORATORIES, 1940-1944

YEAR	SYPHILIS	GONORRHEA
1940	449,256	35,767
1941	908,360	43,591
1942	1,239,399	58,936
1943	948,299	89,249
1944	839,200*	107,915**

\*Includes 10,050 tests made on spinal fluid.

\*\*Includes 22,100 cultures.

TABLE 13.—SYPHILIS CASE RATES BY COUNTY INCLUDING NATIONAL AND STATE AVERAGE BASED ON SELECTIVE SERVICE REPORTS THROUGH DECEMBER 31, 1943.

COLORED RATE PER 1,000	WHITE RATE PER 1,000	TOTAL RATE PER 1,000
1. Holmes 432	1. Calhoun 72	1. Collier 247
2. Gilchrist 373	2. Franklin 67	2. Seminole 228
3. Collier 368	3. Bay 64	3. Hendry 209
4. Lee 368	4. Charlotte 59	4. Flagler 206
5. Highlands 367	5. Escambia 56	5. Palm Beach 208
6. Citrus 364	6. Sarasota 53	6. Lee 193
7. Flagler 349	7. Lee 49	7. Glades 193
8. Seminole 337	8. Gulf 48	8. Citrus 191
9. Volusia 332	9. Monroe 48	9. St. Lucie 182
10. Palm Beach 332	10. DeSoto 48	10. Dixie 180
11. Manatee 324	11. Hendry 48	11. Highlands 176
12. Broward 323	12. Levy 46	12. Broward 175
13. Glades 319	13. St. Johns 45	13. Levy 173
14. Hendry 316	14. Duval 45	14. Martin 173
15. Osceola 315	15. Bradford 43	15. Taylor 171
16. Duval 311	16. Jefferson 42	16. Volusia 170
17. Hillsborough 310	17. Citrus 42	17. Manatee 165
18. Sumter 308	18. Highlands 42	18. Duval 164
19. St. Lucie 306	19. Taylor 41	19. Putnam 162
20. Columbia 304	20. Manatee 40	20. Sarasota 162
21. Martin 302	21. Union 39	21. Alachua 160
22. Bradford 299	22. Volusia 39	22. Columbia 160
23. Bay 298	23. Dixie 39	23. Lake 156
24. Lake 297	24. Clay 38	24. Leon 157
25. Sarasota 297	25. Palm Beach 38	25. Marion 156
26. Levy 295	26. Collier 37	26. Osceola 152
27. Polk 294	27. Jackson 37	27. Madison 149
28. Alachua 292	28. Leon 37	28. St. Johns 146
29. Charlotte 292	29. Nassau 37	29. Gulf 145
30. Taylor 291	30. State Average 36.7	30. Franklin 144
31. Dade 291	30. Wakulla 36	31. Jefferson 142
32. DeSoto 286	31. Walton 36	32. Indian River 141
33. Dixie 286	32. Glades 36	33. Charlotte 142
34. Orange 284	33. Okeechobee 36	State Average 140
35. Okaloosa 284	34. Osceola 36	34. Brevard 138
36. Pasco 283	35. Flagler 35	35. Bay 137
37. Pinellas 282	36. Dade 35	36. Hamilton 132
State Average 279	37. Marion 35	37. Orange 132
38. Putnam 274	38. Washington 34	38. Wakulla 132
National Avg. 272	39. Indian River 34	39. Sumter 131
39. St. Johns 258	40. Broward 34	40. Dade 131
40. Okeechobee 256	41. Columbia 34	41. Bradford 127
41. Madison 256	42. Pasco 34	42. DeSoto 127
42. Union 255	43. Brevard 33	43. Escambia 127
43. LaFayette 250	44. Hillsborough 33	44. Pinellas 125
44. Suwannee 247	45. Orange 33	45. Gadsden 125
45. Clay 246	46. St. Lucie 33	46. Clay 122
46. Escambia 245	47. Holmes 32	47. Nassau 123
47. Marion 241	48. Martin 32	48. Polk 121
48. Leon 241	49. Okaloosa 32	49. Hernando 118
49. Gulf 240	50. Hamilton 31	50. Hillsborough 116
50. Franklin 240	51. Sumter 31	51. Union 116
51. Indian River 232	52. Baker 30	52. Suwannee 113
52. Nassau 237	53. Hardee 30	53. Baker 112
53. Brevard 238	54. Hernando 29	54. Pasco 110
54. Hernando 232	55. Putnam 28	55. Gilchrist 106
55. Wakulla 230	56. Pinellas 27	56. Okeechobee 102
56. Baker 224	57. Seminole 27	57. Monroe 102
57. Hamilton 222	58. Santa Rosa 27	58. Jackson 92
58. Monroe 204	59. Polk 26	59. Calhoun 86
59. Hardee 195	60. Alachua 26	60. Walton 65
60. Jefferson 188	61. Lake 25	61. Holmes 64
61. Washington 183	62. Madison 25	62. Okaloosa 62
62. Gadsden 183	63. LaFayette 24	63. Washington 62
63. Walton 179	National Avg. 23.5	64. LaFayette 60
64. Jackson 175	64. Suwannee 21	65. Santa Rosa 50
65. Santa Rosa 168	65. Liberty 21	66. Hardee 49
66. Calhoun 111	66. Gilchrist 20	National Avg. 48
67. Liberty 100	67. Gadsden 17	67. Liberty 40

TABLE 14.—BUREAU OF VENEREAL DISEASE CONTROL—ANNUAL REPORT—1944.

Reported Cases of Syphilis according to Stage of Infection, Pregnancy Status, Race and Sex, Source of Reference and Age Groups, by Counties and For State—1944

COUNTY	By Stage of Infection										Pregnancy	By Race & Sex					Source of Ref.		By Age Group							
	Primary	Secondary	Early Latent	Late Latent	Late		Cong.	Not Stated	Total	White		Colored		Not Stated	Total	*Clinic or Inst.	Priv. M.D.	Not Stated	0-9	10-19	20-29	30-39	40-49	50-over	Total	
					Other	C.N.S.				M		F	M													F
Alachua	16	6	125	162	9	2	10	18	348	7	14	9	152	170	3	348	320	28	14	1	65	102	122	25	19	348
Baker	2	2	3	18	0	0	0	6	31	0	5	7	12	7	0	31	25	6	4	0	0	14	6	6	1	31
Bay	2	20	192	214	0	3	1	5	437	16	49	47	150	191	0	437	407	30	2	1	75	201	115	31	12	437
Bradford	12	12	86	61	0	0	6	16	193	4	12	38	60	83	0	193	185	8	16	3	24	80	53	12	5	193
Brevard	9	9	20	18	6	0	1	10	73	2	4	5	10	52	2	73	37	36	1	0	13	18	24	13	4	73
Broward	17	21	255	154	0	1	19	12	479	19	21	18	231	196	13	479	391	88	13	7	66	213	125	29	26	479
Calhoun	1	0	7	1	0	0	0	0	9	0	1	2	1	5	0	9	8	1	0	0	1	7	1	0	0	9
Charlotte	1	1	6	6	0	0	1	0	15	1	1	3	4	6	1	15	13	2	0	0	3	5	7	0	0	15
Citrus	1	2	5	2	0	3	0	0	13	0	1	1	1	10	0	13	9	4	0	0	1	5	3	2	2	13
Clay	4	3	62	76	0	0	7	3	155	1	8	9	58	76	4	155	147	8	3	3	21	57	41	22	8	155
Collier	2	3	5	8	0	0	0	5	23	0	4	1	9	8	1	23	0	23	5	1	1	7	3	3	3	23
Columbia	5	4	35	37	1	0	3	3	88	1	4	1	31	48	4	88	74	14	3	3	17	30	22	5	8	88
Dade	192	166	786	1110	76	29	79	150	2588	11	326	208	911	1094	49	2588	1739	849	71	32	291	986	717	317	174	2588
DeSoto	1	2	14	28	0	1	5	2	53	3	4	2	17	22	8	53	19	34	2	4	4	18	16	7	2	53
Dixie	0	1	7	4	0	0	0	2	14	0	2	4	4	4	0	14	11	3	1	0	1	5	5	1	1	14
Duval	313	332	1000	1503	25	60	75	601	3909	72	457	370	1317	1703	62	3909	3169	740	155	55	455	1356	1105	505	278	3909
Escambia	71	107	326	257	8	27	15	1	812	10	56	78	270	399	9	812	682	130	28	4	171	372	171	53	13	812
Flagler	7	3	48	36	1	0	7	6	108	2	0	1	46	58	3	108	104	4	9	1	22	36	15	13	12	108
Franklin	82	14	25	11	0	0	2	8	142	0	32	11	88	11	0	142	138	4	1	1	13	101	20	5	1	142
Gadsden	6	4	58	42	1	1	2	6	120	3	4	10	45	57	4	120	89	31	3	1	26	44	29	9	8	120
Gilchrist	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0	1
Glades	0	1	8	20	0	0	2	1	32	0	1	2	22	7	0	32	32	0	0	0	5	12	12	3	0	32
Gulf	1	4	46	30	0	0	0	3	84	3	6	6	21	51	0	84	77	7	9	1	13	33	19	7	2	84
Hamilton	0	0	3	0	0	0	0	0	3	0	1	1	0	1	0	3	3	0	0	0	0	2	1	0	0	3
Hardee	5	1	17	9	0	0	1	1	34	0	8	13	4	9	0	34	6	28	2	1	1	14	10	4	2	34
Hendry	6	1	64	61	1	1	1	0	135	1	10	3	109	11	2	135	135	0	2	1	12	65	38	13	4	135
Hernando	0	0	4	3	0	1	0	1	9	0	2	1	2	4	0	9	7	2	0	0	1	4	3	1	0	9
Highlands	48	14	62	46	0	1	7	5	183	0	33	21	87	37	5	183	154	29	10	5	17	80	51	13	7	183
Hillsborough	86	93	395	746	30	26	21	20	1417	6	200	157	485	540	35	1417	1239	178	26	8	137	565	400	166	115	1417
Holmes	0	2	21	27	0	0	1	0	51	0	7	7	16	20	1	51	50	1	1	1	4	15	13	15	2	51
Indian River	5	1	31	29	0	1	0	1	68	0	1	1	32	33	1	68	28	40	0	2	3	29	22	10	2	68



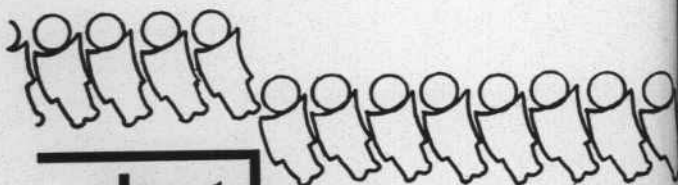
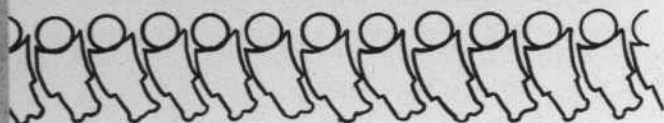
Jackson	2	7	49	46	0	1	8	0	113	5	9	8	39	56	1	113	113	0	1	5	16	50	24	8	9	113
Jefferson	2	6	63	7	0	0	0	0	78	3	3	6	25	43	1	78	77	1	3	2	18	24	22	4	5	78
Lafayette	0	0	0	1	0	0	0	3	4	0	0	0	1	1	2	4	1	3	0	0	0	1	0	2	1	4
Lake	4	5	83	92	0	0	2	15	201	7	17	15	72	85	12	201	134	67	12	3	23	60	60	27	16	201
Lee	7	5	78	54	2	0	1	2	149	1	11	8	63	62	5	149	128	21	8	1	12	67	41	13	7	149
Leon	30	42	174	95	0	8	6	4	359	3	17	23	104	213	2	359	306	53	6	1	63	169	78	34	8	359
Levy	1	2	5	1	0	0	1	0	10	0	1	1	3	5	0	10	9	1	0	1	4	2	2	0	1	10
Liberty	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Madison	1	0	9	3	0	1	2	0	16	2	0	0	5	10	1	16	16	0	0	1	4	5	3	2	1	16
Manatee	5	6	88	71	1	2	3	2	178	1	12	8	104	53	1	178	119	59	2	2	16	73	46	25	14	178
Marion	2	8	106	134	0	0	10	3	263	4	22	19	83	136	3	263	231	32	5	0	49	93	69	34	13	263
Martin	1	0	0	0	0	0	0	6	7	0	0	0	0	0	7	7	7	0	0	0	1	3	2	1	0	7
Monroe	13	12	68	40	0	1	1	7	142	1	21	15	48	57	1	142	134	8	3	1	16	67	41	9	5	142
Nassau	6	10	21	51	4	0	7	15	114	2	8	11	44	46	5	114	83	31	8	9	12	31	27	16	11	114
Okaloosa	11	6	21	14	0	1	8	0	61	0	13	13	9	18	8	61	52	9	3	3	12	26	11	5	1	61
Okeechobee	1	0	11	23	0	0	1	0	36	1	0	1	11	22	2	36	35	1	0	0	3	18	6	8	1	36
Orange	36	22	187	257	10	12	30	26	580	2	59	51	228	216	26	580	425	155	30	9	89	226	145	53	28	580
Osceola	1	0	0	4	0	1	0	0	6	0	3	1	1	1	0	6	2	4	0	0	0	2	1	1	2	6
Palm Beach	49	54	1076	1066	4	12	44	19	2324	11	84	31	1205	907	97	2324	2084	240	51	26	200	917	700	295	135	2324
Pasco	1	5	13	20	0	1	3	12	55	6	4	16	16	19	0	55	8	47	0	1	9	21	11	7	6	55
Pinellas	6	14	112	201	7	4	12	14	370	2	36	28	153	149	4	370	286	84	8	3	45	126	105	52	31	370
Polk	31	29	175	253	5	4	19	10	526	6	61	41	198	200	26	526	401	125	8	9	66	193	163	63	24	526
Putnam	6	6	43	17	3	0	1	6	82	0	7	4	33	33	5	82	62	20	2	0	13	27	24	11	5	82
St. Johns	5	9	59	42	0	2	16	4	137	2	9	10	47	67	4	137	134	3	5	4	29	59	22	12	6	137
St. Lucie	4	8	69	72	0	1	0	11	165	0	2	14	69	62	18	165	155	10	8	0	18	63	54	17	5	165
Santa Rosa	0	6	14	12	0	0	1	0	33	0	7	4	7	15	0	33	32	1	0	1	9	16	3	2	2	33
Sarasota	2	8	67	44	1	0	4	13	139	2	9	10	54	59	7	139	98	41	11	3	15	44	37	22	7	139
Seminole	4	12	115	188	0	1	13	2	335	3	9	11	160	152	3	335	287	48	23	9	32	142	87	34	8	335
Sumter	0	2	29	52	0	0	0	2	85	0	5	6	23	51	0	85	30	55	2	0	11	23	21	17	11	85
Suwannee	0	1	4	2	0	1	0	1	9	0	1	2	2	3	1	9	9	0	0	0	4	0	3	1	1	9
Taylor	4	0	23	31	0	0	0	0	62	0	10	13	10	28	1	62	38	24	4	2	14	17	14	10	1	62
Union	0	0	1	5	0	0	0	5	11	0	2	0	5	4	0	11	10	1	3	0	1	2	3	0	2	11
Volusia	16	22	126	109	1	4	7	25	310	2	27	26	119	136	2	310	227	83	65	4	29	98	60	30	24	310
Wakulla	0	0	10	4	0	1	0	1	16	0	3	2	2	9	0	16	13	3	0	0	4	3	5	1	3	16
Walton	1	2	18	13	0	0	1	23	58	0	11	8	10	21	8	58	55	3	23	1	8	13	7	2	4	58
Washington	4	8	21	13	0	0	1	0	47	0	3	10	21	13	0	47	45	2	1	1	12	14	12	7	0	47
State Hosp.	1	0	4	53	1	97	3	0	159	0	10	1	1	1	146	159	159	0	1	3	8	16	43	41	47	159
Camp Blanding	31	16	9	4	3	6	0	0	69	0	57	0	11	0	1	69	69	0	0	0	8	46	15	0	0	69
Naval Air Station	27	0	0	1	0	0	0	15	43	0	24	0	17	0	2	43	43	0	1	0	19	19	4	0	0	43
Out of State	11	8	19	23	3	7	2	10	83	0	25	16	22	12	8	83	67	16	10	0	13	27	11	8	14	83
Fla. T.B. San.	0	0	1	0	0	0	0	1	2	0	1	0	1	0	0	2	2	0	0	0	0	1	1	1	0	2
Gov't Hospital	0	0	0	3	5	1	0	8	17	0	3	0	12	0	2	17	17	0	3	0	0	1	1	5	7	17
State Prison	3	6	28	29	0	0	0	23	89	0	14	1	66	8	0	89	89	0	6	0	10	29	30	10	4	89
Florida Total	1224	1176	6715	7869	208	326	473	1179	19170	228	1894	1471	7299	7887	619	19170	15591	3579	698	241	2378	7309	5183	2180	1181	19170

(\*Includes unknown Source of Reference)

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**about**

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# *Florida* **HEALTH NOTES**

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JACKSONVILLE • MARCH, 1945 • VOL. 37 • No. 3

**THE HANDICAPPED**

# The State Board of Health

ESTABLISHED 1890

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Governor of Florida

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# Florida HEALTH NOTES

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## THE HANDICAPPED

Health Notes this month endeavors to describe some of the work being done for Florida's handicapped. The "handicapped" are those individuals who have some physical, mental or emotional impairment which prevents or impedes their normal adjustments in life. Of the approximate 2,000,000 potentially employable persons vocationally handicapped by serious disabilities in the United States, Florida has her full share.

Our state has already established a number of institutions and agencies for the rehabilitation and care of the handicapped. Among these are: the Florida Farm Colony for the Feebleminded, the State School for the Deaf and Blind, the State Hospital for the mentally ill, the State Tuberculosis Sanatorium, the Florida Crippled Children's Commission, the Vocational Rehabilitation Service of the Florida State Board for Vocational Education and the Florida Council for the Blind.

All of these agencies render valuable services but much remains to be done to care adequately for the increasing number of handicapped persons in our growing state. The best thinking, planning and public support possible will be required to solve this important problem.

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Cover picture this month is of the beautiful and modern Hope Haven Hospital for Crippled Children, Jacksonville. It is operated primarily for indigent children and is closely cooperative with the city, county and state health departments and social agencies. Conceded to be the outstanding building of its kind in Florida, Hope Haven is governed by the rules of the Florida Crippled Children's Commission.

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# VOCATIONAL REHABILITATION SERVICE

by **CLAUD M. ANDREWS**, *State Director*

*Vocational Rehabilitation Service*

*State Board of Vocational Education, Tallahassee, Florida*

The Florida Vocational Rehabilitation Service is not new. In 1927 the State Legislature appropriated a small fund and directed the State Board for Vocational Education to operate a rehabilitation service under the provisions of the National Rehabilitation Act of 1920. Under this Act the states could receive limited Federal financial assistance on a matching dollar for dollar basis.

During depression years the state and Federal appropriations remained small and the rehabilitation staff could serve only a small number of handicapped persons in any one year. Rehabilitation methods were limited to guidance, training, and placement of handicapped persons. To a limited extent the fitting of artificial appliances was done. Nevertheless, prior to 1944, there were approximately 2,500 handicapped persons rehabilitated.

In October, 1943, Public Law 113 which broadened and liberalized the National Rehabilitation Act of 1920 became effective. Under this law the rehabilitation needs of the handicapped can be much better served. Already over 1,500 persons have been rehabilitated under its benefits.

The Florida Rehabilitation Service operates a program based on the following factors, any or all of which may be required for successful adjustment of the handicapped:

- ★ Early location of persons in need of rehabilitation to prevent the disintegrating effects of idleness and hopelessness
- ★ Medical diagnosis and prognosis, coupled with a vocational diagnosis as the basis for determining an appropriate plan for the individual
- ★ Vocational counseling to select suitable fields of work by relating occupational capacities to job requirements and community occupational opportunities



The gentleman dispensing cokes and potato chips to his Merchant Marine friends is William Van Meter, operator of the canteen at the Tampa United Seamen's Center. While in active service in the Merchant Marine, Mr. Van Meter developed cataracts on both eyes. It was through the new rehabilitation program of the Florida Council for the Blind that his eyes were operated on by Dr. R. R. Duke at the Tampa Municipal Hospital. Van Meter now impatiently awaits the time when he will get his glasses and perhaps again will be able to "go down to the sea in ships." (Staff photo)

- ★ Medical and surgical treatment to afford physical restoration, and medical advice in the type of training to be given and in the work tolerance of the individual
- ★ Physical and occupational therapy and psychiatric treatment as a part of medical treatment where needed
- ★ Vocational training to furnish new skills where physical impairments incapacitate for normal occupations, or where skills become obsolete due to changing industrial needs
- ★ Financial assistance to provide maintenance and transportation during training
- ★ Placement in employment to afford the best use of abilities and skills in accordance with the individual's physical condition and temperament, with due regard to safeguarding against further injuries
- ★ Follow-up on performance in employment to afford adjustments that may be necessary, to provide further medical care if needed, to supplement training if desired

*Any person who is at least sixteen years old and who is vocationally handicapped by reason of a disability is eligible for vocational rehabilitation service.* The Rehabilitation Service does not maintain institutions for the training, treatment, or care of disabled persons. It utilizes existing institutions, both public and private agencies, shops, industries, and individuals who can render rehabilitation services to its clients. All case services are provided on an individual basis in accordance with the interests, capacities and needs of the handicapped person being served.

Of special interest to readers of HEALTH NOTES will be the provisions for assisting handicapped persons to obtain medical and surgical treatment needed in their vocational rehabilitation. This service is operated with the advice a medical advisory committee composed of Dr. Herbert L. Bryans, Chairman, Dr. James L. Anderson, Mr. W. E. Arnold, Dr. F. L. Fort, Dr. Henry Hanson, and Dr. R. D. Thompson.

The following practices will be followed in regard to treatment and physical restoration services:

- ★ Only persons whom it appears could be made employable through physical restoration and other rehabilitation services will be accepted for treatment of any kind.
- ★ Physical rehabilitation will be granted only on an economic need basis.

- ★ It will be granted only on the advice of an accredited physician or surgeon and will be granted for the purpose of making possible for rehabilitation of the client involved.
- ★ Physical rehabilitation will not be granted if the client is eligible for such services under any other organization.
- ★ Only those conditions that are relatively stable and remediable within a reasonable length of time may be treated.
- ★ Acute illness and long-term chronic cases are not eligible. For example, it is not intended that appendicitis, pneumonia, or active tuberculosis be treated.
- ★ Hospitalization is limited to ninety days.

Rehabilitation patients may choose their own physicians from qualified panels. Physicians are paid for their services on each individual patient. Hospitals used are those listed in the American Medical Directory. They are paid their per diem rate. Out patient services are provided under certain conditions upon the recommendation of the attending physician.

Doctors and health workers especially are invited to refer any patient whom they believe to be feasible for and in need of rehabilitation services. Within recent months plans have been completed for physical rehabilitation services on nearly a hundred persons. Twenty of these have already returned to work and are earning a livelihood. The others show gratifying progress toward rehabilitation.

Case studies are revealing that many 4-F registrants for Selective Service can be made employable or their present employability improved by medical or surgical treatment and it is expected that many of these will take advantage of this opportunity for improving their conditions and helping their country by preparing for essential jobs.

Any unemployed handicapped person who wants to work and who can be made employable or any handicapped person who needs rehabilitation service to become well adjusted in his present work should apply for rehabilitation service. More than 4,000 persons have already received the benefits of this program and over 2,000 are currently enrolled for some kind of rehabilitation service. Florida's handicapped who have been rehabilitated are showing an employment record of which we are proud. Their income tax payments are proving that the money spent on them was a wise investment. Human labor was never more important than now.



The three young women in the foreground were enrolled at the Jones Business College, Jacksonville, through the District Vocational Rehabilitation Office of the State Department of Education. The girl using the dictaphone has spent most of her life in childrens' hospitals. She was enrolled for a business course after a number of tests showed that this would be the best possible channel for employment in her case. Of the pretty young woman at the right, director Glenn D. Calmes says: "Originally referred to us in 1938, too handicapped to benefit from rehabilitation service. We were instrumental, however, in getting a WPA teacher to go to the home to give academic instruction. Last summer she was able to attend a job clinic. We fitted her with new braces and subsequently enrolled her for a business course."

The girl in the middle background has a speech defect caused by a paralysis of the facial muscles. She wanted to do photo retouching, but turned to stenography when the former proved too nerve straining.

(Staff photo)

The gentleman handling the molars with such authority formerly sold papers in front of Jenks restaurant, Jacksonville, before being brought to the attention of the rehabilitation service. His average paper sales totaled about \$12 a week. He was given a course in dental mechanics and today (four years later) he owns his own laboratory, with an estimated income of \$75 a week. This man has both legs disabled. He wears braces and uses crutches. On the job, he has a stool with castors and is able to pull himself around the laboratory. Said Mr. Calmes: "We feel it was well worth the money spent for his dental course, since it did equip a badly handicapped person to do work which is essential today, and which provides self respect and enough income for comfortable living."

(Staff photo)





To these youngsters the lack of eyesight seems to mean very little in their everyday activities at the Florida School for the Deaf and Blind. They read by Braille, and their handiwork would put many a sighted person to shame. Even their supervised play seems easy and matter-of-fact. Here, we see Miss Clarissa Pickles, instructor, watching a youngster master a tedious stitch.

(Staff photo)



The "operators" and "customer" shown here are students at the Florida School for the Deaf and Blind at St. Augustine. Beauty culture is a popular course for the hard-of-hearing at this school, and many a young woman, handicapped by deficient hearing is preparing herself against the day when she will be forced to compete with more normal-hearing persons in the business world. Mrs. Agness Solano, instructor, looks on approvingly as her girls go right about the intricate job of giving a permanent wave.

(Staff photo)

# THE PROGRAM OF THE CRIPPLED CHILDREN'S COMMISSION

by **EDNA KNOWLTON, R.N.**, *Orthopedic Nursing  
Consultant, Florida Crippled Children's Commission  
Capital Building, Tallahassee, Florida*

The Florida Crippled Children's Commission was created by a movement sponsored by the American Legion, enacted into law in 1929 and amended in 1939. The Commission is composed of five members appointed by the Governor, one from each Congressional District, for four year terms. Members serve without compensation except for expenses when on official business.

Through state and Federal funds the Commission provides facilities for the examination, care and treatment of all indigent or partially indigent crippled children up to twenty-one years of age, regardless of marital status, race, creed or color. Any crippled child regardless of financial status may attend clinic for diagnostic purposes. A crippled child is defined as "any person of normal mentality under the age of twenty-one whose physical functions or movements are impaired by accident, disease or congenital deformity."

For this work Florida is divided into five districts, roughly corresponding to the Congressional Districts, with an orthopedic operating unit in each. These units, with headquarters in St. Petersburg, Jacksonville, Pensacola, Miami and Orlando, consist of an orthopedic surgeon, an assistant surgeon, orthopedic field nurse, secretary and physiotherapist.

Each unit conducts a weekly diagnostic and treatment clinic. Only those crippled children of normal mentality who may be improved by treatment and whose parents or guardians are unable to pay in whole or in part the cost of treatment are considered eligible for placement under the program.

In addition to the weekly clinics a number of rural clinics are held each year which serve to locate crippled children and offer recommendations. In these clinics the child receives a physical examination and an X-ray if indicated. The physiotherapist carries out treatments if recommended. Often these cases are sent to a specialist for the removal of tonsils or adenoids, to have hare-lip and cleft palates repaired or to have scars from old burns removed. The nurse and physiotherapist interpret the doctor's recommendations to parents or guardians.

(Continued on Page 51)



The two "Big leaguers" shown here are patients at the American Legion Hospital for Crippled Children at St. Petersburg. The young chap at the left was stricken with polio last August. Braces reaching to his arms give him enough support to sit up. The youngster at the right has an elbow fracture which also calls for exercise. Hence, the recreation of pitching ball is also an important phase of recovery in disguise.

It was the American Legion who pioneered the Crippled Children's rehabilitation work in Florida in the early 1920s. The hospital is under the supervision of Registered Nurse, Mrs. Golda Hasson. (Staff photo)



Mrs. Pearl Brockman, physiotherapist at the American Legion Hospital for Crippled Children is applying a treatment to one of her young polio charges. To the extreme left is a washing-machine type of gadget which keeps the cloths boiling hot. The nurse's aid puts them through a wringer and passes them on to Mrs. Brockman who knows "exactly where and how they are to be applied." The patient was stricken last December. (Staff photo)

# EYE MEDICAL PROGRAM— FLORIDA COUNCIL FOR THE BLIND

by **R. HENRY JOHNSON**, *Executive Director*  
*Florida Council for the Blind*  
*Wallace S. Building, Tampa 2, Florida*

Florida law provides that the Florida Council for the Blind shall "inquire into the causes of blindness, inaugurate preventive measures, provide for the examination and treatment of the blind or those threatened with blindness for the benefit of such persons, and shall pay therefor, including necessary expenses."

Vested two years ago with responsibilities for effecting this law, the Florida Council for the Blind immediately sought and received the cooperation of the Florida Society of Ophthalmology and Otolaryngology and of the Florida Medical Association. Dr. Shaler Richardson of Jacksonville, then president of the Society, was authorized to cooperate with the Council by appointing an Eye Medical Advisory Committee. This original committee was composed of Dr. S. B. Forbes, Tampa, Chairman; Dr. Bascom Palmer, Miami; Dr. Charles Boyd, Jacksonville. Early in 1944 this committee was expanded to include Dr. William Sayad, West Palm Beach, and Dr. Charles Grace, St. Augustine, in addition to Dr. Richardson.

This professional advice has enabled the Council to initiate its program of sight conservation on a sound basis.

The following six-point Sight Conservation Program was suggested and approved by the Eye Medical Advisory Committee:

- ★ Study the causes of blindness and execute corrective measures for preventing blindness
- ★ Provide for eye examinations, treatment, surgery and after care for those needing such care
- ★ Stimulate participation in community programs for sight conservation, including the promotion of legislation, safety controls, other measures
- ★ Publicize materials on sight conservation, including recommendations for school, office and home lighting; the wearing of properly-fitted glasses, others
- ★ Study, interpret and set up standards for the maintenance of sight-saving classes
- ★ Cooperate in sight conservation with state, county and city health departments, state and county school authorities, the Crippled Children's Commission, state and county medical associations, the Florida School for the Deaf and Blind and other agencies

In the beginning, because of limited state appropriations members of the Eye Medical Advisory Committee and other physicians agreed to donate their own time and services in providing professional treatment for Florida's indigent blind. In 1944, however, the Council began receiving Federal funds to provide medical care for employable persons, under legislative provisions of the 78th Congress. Florida was then the seventh state in the nation with an approved rehabilitation program for the visually handicapped.

For continuing the program with the aid of Federal funds, the Council and the Medical Advisory Committee has established a fee schedule for paying physicians for services to employable clients. Private physicians have continued to render services without charge for unemployable indigents. The Eye Medical Advisory Committee has emphasized that only indigents should be served by the medical program of the Council.

By special agreement with the State Welfare Board, case workers of the District Welfare Boards in Florida are the principal sources of referrals to the Council. **Any indigent citizen of Florida needing specialized eye medical care may make application for the services of the Council by reporting to his nearest District Welfare Office.** Local health units of the State Board of Health may also refer clients. In several places the clinical services of the State Board of Health are utilized by the Council in obtaining preliminary diagnostic medical information.

The Council's program of providing eye medical services for indigents has enabled many otherwise useless persons to become normal participating citizens. A program which creates employed tax payers out of unemployed tax recipients seems sound economically and socially.

### SIGHT CONSERVATION WEEK, APRIL 8-18

During April, the Bureau of Health Education, Florida State Board of Health, Jacksonville 1, Florida, will be distributing films specially selected by the Florida Council for the Blind on sight conservation. Make reservations early for use with schools, civic clubs or PTA's. No charge except express.



## PUBLIC INTEREST IN THE HANDICAPPED

by **MRS. LOUISE C. TRIGG**, *Executive Secretary*  
*Florida Association for Crippled Children and Adults*  
442 W. Lafayette Street, Tampa, Florida

The problem of rehabilitation of the handicapped is far too great to be solved through private philanthropy or public funds alone. Much can be done through heightened public interest, local and statewide, in both prevention and rehabilitation.

Not until late in the 19th century did a growing, intelligent interest and a social concern for the crippled lead to a rather widespread effort to provide medical and nursing care. With increased public interest and understanding, the meaning of the word "crippled" has broadened, the word "handicapped" often being substituted, to include not only the child with a shortened leg or missing arm but individuals with other types of impairment—speech defects, hearing and visual impairment, or any deviation from the normal tending to handicap.

Growing interest in education for the handicapped has been shown and should be encouraged. Education for the handicapped includes remedial speech work; lip reading; sight saving classes; classes for the mentally retarded; classes for children with motor handicaps, including those needing restricted activity because of heart or other conditions and the home instruction of children seriously crippled or with convulsive disorders. Florida's classes for the handicapped in public schools are few in number at present because of the shortage of teachers with required training and a lack of public understanding of the needs. Home training is under way in one or two counties.

Statistics show that ten percent of the school children have speech disorders, half of which are severely afflicted, and from four to seven percent have sufficiently defective hearing to need special work. Children's Bureau's Dr. Elise Martens states that from one-fourth to one-third of the children on Crippled Children's Commission rolls need special educational service. The Florida Crippled Children's Commission had 5,010 children registered on June 30, 1943, indicating that Florida probably has, as a conservative estimate, over 1,000 children in need of special education.

Special education entails more than a teacher and a class room. Transportation and an attendant in the class-room are needed for some types of handicapped. The child with defective vision or defective hearing must first be examined and the defects analyzed. In some cases after proper and timely treatment the child's trouble is corrected and he returns to regular classes.

There is need for a greater public understanding of the cerebral palsied, persons handicapped by disturbed coordination, a condition caused by the malformation, injury or destruction of the motor nerve cells of the brain. Many people think these individuals are of low mental capacity. Numerous studies, however, indicate that approximately 75% of the cerebral palsied have intelligent quotients ranging from 70 to superior.

Dr. Winthrop Morgan Phelps calculates from surveys that there is an average case load of 96 cerebral palsied children under 16 years of age for every 100,000 population and that of this 96, fifty-four can be benefited from treatment, training and education. Florida with its approximate population of 2,000,000 would have about 1,920 cerebral palsied under 16, and 1,080 of them should be receiving training and education.

Only through the cooperative, coordinated efforts of public and private agencies and the stimulation of greater public interest will the problem of the handicapped in Florida be met.

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#### PROGRAM OF CRIPPLED CHILDREN'S COMMISSION (Continued from Page 40)

Through contacts with the Commission, hospital facilities are available in each unit. These are required to furnish the necessary services and to meet approved high standards. In most districts convalescent homes are available where services are purchased by the Commission. These homes are required to have full and complete facilities for crippled children.

Cooperation with other agencies is important. Public health nurses assist in some instances to follow-up patients, carry out recommendations and get patients to return to the clinic. When a child reaches the age of sixteen years he may be referred to Vocational Rehabilitation for job training in which his disability will be the least handicap. Since 1936, the Children's Bureau has cooperated with the Commission each year in furnishing services to the crippled child.

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*The back cover picture shows how all Tampa school children are given hearing tests each year. A class at the Lee School in Tampa is seen taking the tests under the direction of Mrs. Ethel M. Bolesta, audiometer technician supplied by the Association for Crippled Children and Adults of Hillsborough County. Mrs. Jean Moore, supervisor of public health nurses with the Hillsborough County Health Unit, assists.*

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# *Florida* **HEALTH NOTES**

PUBLISHED BY THE FLORIDA STATE BOARD OF HEALTH

JACKSONVILLE • APRIL, 1945 • VOL. 37 • No. 4

**CANCER CONTROL**

# The State Board of Health

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# *Florida* **HEALTH NOTES**

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ESTABLISHED 1890

## CANCER

Never before have we been so aware of the life saving power of scientific research. Out of the laboratories and on to the firing lines have gone sulfa drugs, penicillin, dried blood plasma. We have seen the wonders of the march of science against the killers yellow fever, small-pox, diphtheria, typhoid.

Today research against cancer stands on the threshold of new and great advances. It has already given us the methods of producing and controlling the disease in laboratory animals. It has begun to give us the knowledge of how cancer cells differ from normal cells. The needs for more and more cancer research, however, are still legion.

Seventeen million Americans, now living, it is estimated, will die of cancer unless something is done. At least 5,500,000 of these could be saved by the application of known means, the America Cancer Society estimates....

You who read this are one of the "means" by which these lives can be saved. Learn the danger signals that may mean cancer and learn the ways in which the risk of cancer may be decreased. Pass the information on to others.

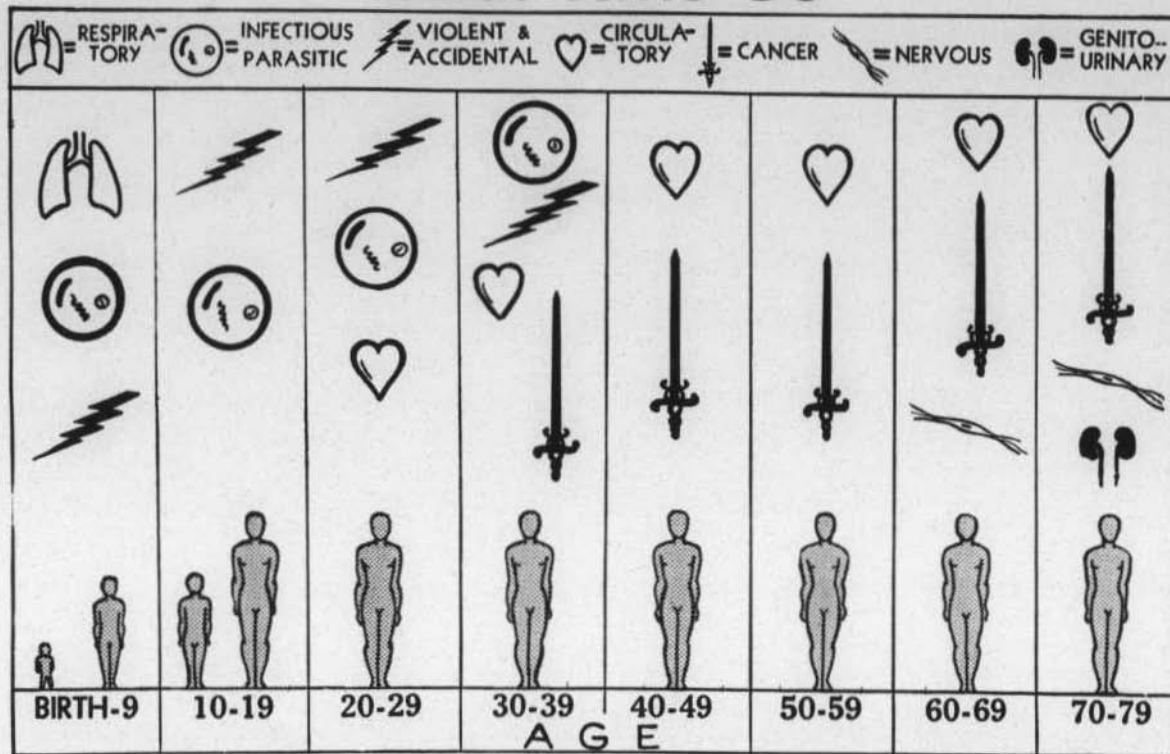
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# What Kills Us



Chief causes of death at different ages, arranged in order of importance from top to bottom.

## IS CANCER ACTUALLY INCREASING?

By **GERRY R. HOLDEN, M. D.**

*Jacksonville, Florida*

According to the vital statistic records kept throughout the country the number of deaths from cancer is increasing. But this does not mean that cancer is more prevalent today than it was years ago. To understand this several factors must be considered.



*(Staff photo).*

The reporting of life and death in the United States has increased in accuracy and many more deaths are being reported. For example, in Florida the death rate from cancer increased 70 percent in two years when in 1917 the State Board of Health improved its methods of collecting and recording death reports.

A second factor of importance is that the ability and knowledge of the doctors who sign these reports has advanced tremendously during the last few decades. The diagnoses given by the average doctor of today are more correct than those submitted by the practitioner thirty odd years ago.

Also we must realize that medicine today recognizes as cancer many conditions which in past years were ignored or not understood. For instance, thirty years ago we were told that primary cancer of the lung was exceedingly rare. Now we know that it is one of the most frequent of malignant conditions.

Another important factor is that the expectancy of life has been so increased that we have today many more people of the "cancer age," older people who are potential victims of cancer. In earlier years many such people would have died of other conditions but now, living on to old age, they help swell the number of cancer victims.

*(Continued on Page 66)*

## CANCER FACTS FOR MEN

*Resume of the American Cancer Society pamphlet, "Cancer Facts for Men"*

The most important thing for men to know about cancer is that its first symptoms are almost always painless. They appear trivial and harmless. Indeed they seem to amount to nothing; yet they often indicate the presence of the most serious disease that afflicts mankind. Each year upwards of 70,000 men in the United States die of cancer.

Many cancer deaths could be prevented if men could be made to realize the importance of the symptoms which seem so unimportant; if they could be persuaded to consult a well trained doctor. Consultation early in the course of the disease is essential, as the percentage of cures drops with startling rapidity as the disease advances. Delay is the partner of death.

It takes a man with courage and intelligence to go to a doctor for an examination for something that causes no pain, and little inconvenience. But this procedure is basic to cancer prevention and cure.

Cancer in men is most frequently found in the stomach and intestines, prostate gland, rectum, lungs, lip and mouth, throat and skin. Cancer in each of these locations presents more or less characteristic signs and symptoms. These should be known by all men so that when they are noticed the family physician can be consulted at once. What are these symptoms?

**The stomach and intestines.** Any aversion for food (especially meat), distress after meals, sudden loss of flesh or an attack of dyspepsia in a man past forty who has hitherto enjoyed good digestion should be signals for a complete examination, including x-ray analysis of the stomach content.

**The prostate gland and bladder.** Symptoms of cancer of the prostate are the slowing of the urinary stream, frequent voiding during the night, blood in the urine, difficulty in voiding. Blood in the urine should be investigated at any age, but especially in a man past forty.

**The lungs.** Cancer of the lungs is characterized by a persistent cough without fever, loss of flesh, shortness of breath, and bloody sputum. An x-ray examination will be of great value in making an early diagnosis.

**The lips and mouth.** Any persistent sore on the lips should be examined especially if its edges are hard and the patient is a chronic pipe smoker. In the mouth a painless sore on the margin of the tongue, the gums or cheek should receive attention. Such sores often occur in the floor of the mouth. Do not wait for pain. See your doctor. Do not allow a painless sore to be cauterized with a mild caustic.

**The throat.** Fortunately, cancer of the throat is rare. It may be a persistent sore in the region of the tonsils. Hoarseness for more than a week or ten days might be a sign of cancer of the vocal cords. Proper and early treatment will cure cancer in any of these locations.

**The skin.** Skin cancer is by far the most frequent lesion encountered in men and involves the greatest distress and discomfort. Skin cancers occur at any age, but are more frequent during old age. They require unceasing care. Death comes only after months of suffering, during which the patient realizes he might have been cured if he had been treated when the cancer was only a small scaly spot. Skin cancers are most frequent on the face, back of the hands, and the neck, though they may occur on any part of the body. They may arise from a mole or from the margin of a deep scar. If you find a scaly spot on the face or hands, see a doctor at once.

(Continued on Page 62)



## COMBATting CANCER'S ALLIES: FEAR, IGNORANCE, DELAY

By **MRS. MALCOLM SMITH**, *State Commander, Florida  
Division Field Army of the American Cancer Society  
711 Stovall Building, Tampa 2, Florida*

Many women fear cancer. Some admit it, some attempt to ignore it, and more and more women, fortunately, are fighting that fear and overcoming it by knowledge. Why do so many of us who feel that there might be something wrong put off consulting a doctor? Why delay the mental relief of knowing that cancer is not present, or the realization that the condition has been recognized in time for successful treatment? For cancer is **curable**, but only if it is diagnosed and treated in its early stages. Fear, ignorance and delay are cancer's allies.



(Staff photo).

Cancer is a universal disease. It attacks individuals of any age, race, color or creed. Yes, any age, for babies are born with cancer, and last year 18,000 children under 14 died of it. More Americans died of cancer during **each** of the last three years, than the total number who died in combat or from battle wounds during the same three war years combined.

Cancer is definitely a personal problem. Unless the individual is alert to the danger signals and willing to consult a physician when suspicious symptoms first appear, there is much less successful treatment. Periodic physical examinations provide the best insurance against cancer. At least once a year all sites where cancer is likely to develop should be examined.

Pain is a late symptom of this disease. Do not wait until pain forces you to consult a doctor. Be alert for early signs which may mean cancer and which should always mean a prompt visit to your family physician.

Watch for:

1. Any persistent lump or thickening, particularly in the breast.
2. Any irregular bleeding or discharge from any body opening..
3. Any persistent or unexplained indigestion, particularly if accompanied by a distaste for meat.
4. Any sore that does not heal normally, especially about lips, tongue or mouth.
5. Any sudden change in the form or rate of growth of a mole or wart.

Among many health practices which are considered important in avoiding cancer as well as in maintaining general good health, a few are listed here:

1. Avoid burns, particularly eating foods which are too hot.
2. Avoid food or drink which brings distress.
3. Establish bowel regularity; have hemorrhoids treated.
4. Keep teeth, gums, tongue, mouth clean.
5. Have injuries resulting from childbirth corrected.
6. Avoid too tight a restriction of breasts.
7. Protect skin from excessive sun or wind.

Eminent physicians the world over have agreed that the only known successful methods of treating cancer are surgery, x-ray and radium or a combination of these. Beware of quacks using serums or guaranteeing cures.

There is more hope for the cancer victim now than ever before in history, more knowledge has been gained about the disease in the last twenty years than in all preceding centuries. Scientists, physicians and citizens interested in general welfare are working together to spread information about cancer and to assist cancer patients.

Each individual must join with scientific and medical men in the fight to defeat cancer, overcome fear, ignorance and delay.

## CANCER FACTS FOR MEN (Continued from Page 59)

To delay treatment is dangerous because cancer grows rapidly and the cells from the margin spread in all directions. Early cancer is usually limited to one spot and can therefore be removed or destroyed. If left alone, it spreads out, travels through the blood or other body fluids to remote and inaccessible parts of the body. Delay if continued is fatal.

Surgery, x-ray and radium alone or in combination are the approved methods of treating cancer. There are no "quack" or easy remedies. Hundreds of such fake treatments such as salves, serums or plasters, are advertised and advocated by word of mouth. The American public pays dearly for their use in cash, in suffering and in sorrow. There are no records of reliable and helpful serums, injections or diet treatments.

Cancer control needs the support and hearty cooperation of every American citizen. Cancer is increasing because our population is growing older. Cancer can be prevented. Early cancer can be cured.

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**FELLOWSHIPS IN HEALTH EDUCATION**

Fellowships for graduate work in health education are being offered to qualified applicants by the U. S. Public Health Service, in cooperation with the National Foundation for Infantile Paralysis. Surgeon General Thomas Parran has announced. These fellowships for the collegiate fall term of 1945 are being awarded to meet present and future needs for trained health educators in schools, communities, and local, State and Federal health departments.

Men and women between the ages of 22 and 40 who are citizens of the United States and who hold a bachelor's degree from a recognized college or university may apply.

Fellowships will lead to a master's degree in public health. The twelve months' training will consist of nine months in the School of Public Health at the University of North Carolina, Yale University or the University of Michigan, and three months' field experience in community health education under supervision. Applicants must meet the requirements for admission to the Schools of Public Health. Training in science, sociology, education, and psychology, plus experience working with people are desirable prerequisites.

The fellowships provide a stipend of \$100 a month for twelve months, full tuition, and travel for field experience. Candidates must pay their travel to and from the university at the beginning and end of training.

Fellowship application forms may be obtained from the Surgeon General, U. S. Public Health Service, Washington, D. C. Applications must be accompanied by a transcript of college credits and a small photograph, and must be in the office of the Surgeon General not later than June 1, 1945.



*The x-ray machine shown here is used at the municipal hospital in Tampa for treating cancer, and is among the few "best" in the State. We show the picture primarily to give the prospective patient an idea of the type "tools" which will be used to control her disease—that the treatment is simple and painless. The pretty patient is a bona fide one who volunteered to be our subject while awaiting her turn under the curative-rayed machine. The attendant is a member of the technical staff of the hospital, and is always at the side of the patient during the time of actual treatment. (staff photo)*

## CANCER DEATHS, LOCATION SPECIFIED, BY COLOR, BY SEX, FLORIDA, 1943

LOCATION	TOTAL		WHITE		COLORED	
	Male	Female	Male	Female	Male	Female
Lip	8	3	8	1		2
Tongue	16	6	16	5		1
Mouth	11	4	11	1		3
Jaw Bone	7	5	5	3	2	2
Unsp. Parts Buccal Cavity	1	1	1	1		
Pharynx	29	10	26	9	3	1
Esophagus	31	4	21	2	10	2
Stomach	169	91	139	75	30	16
Duodenum	1				1	
Rectum and Anus	42	46	38	39	4	7
Intestines (Except Duodenum)						
and Rectum	89	101	80	92	9	9
Liver and Biliary Passages	72	67	63	56	9	11
Pancreas	32	24	27	22	5	2
Mesentery and Peritoneum	3	1	2	1	1	
Other and Unspecified Sites of						
Digestive Organs	1	4	1	4		
Larynx	15	4	12	3	3	1
Bronchus	22	5	20	4	2	1
Lung	73	31	66	30	7	1
Mediastinum and Unsp. of						
Respiratory System	2	1	2	1		
Cervix		105		83		22
Other and Unspecified						
Uterus		203		143		60
Ovary		43		34		9
Fallopian Tube and Parametrium		2		2		
Vagina		2		1		1
Vulva		2		2		
Other and Unspecified Sites of						
Female Genital Organs		1		1		
Breast	3	202	1	156	2	46
Scrotum	1				1	
Prostate	128		110		18	
Testes	2		2			
Penis	6		4		2	
Kidney	14	13	13	12	1	1
Bladder	53	18	53	16		2
Other and Unspecified Sites of						
Urinary Organs		2		2		
Skin	46	18	39	16	7	2
Glioma	5	6	5	6		
Other and Unspecified Sites						
Brain and Central Nervous Sys.	5	5	5	4		1
Bones	14	15	10	10	4	5
Thyroid Gland	1	1	1	1		
Nasal Cavity and Accessory Sinuses	1	1	1			1
Other and Unspecified Organs	58	56	52	40	6	16
ALL FORMS	961	1,103	834	878	127	225

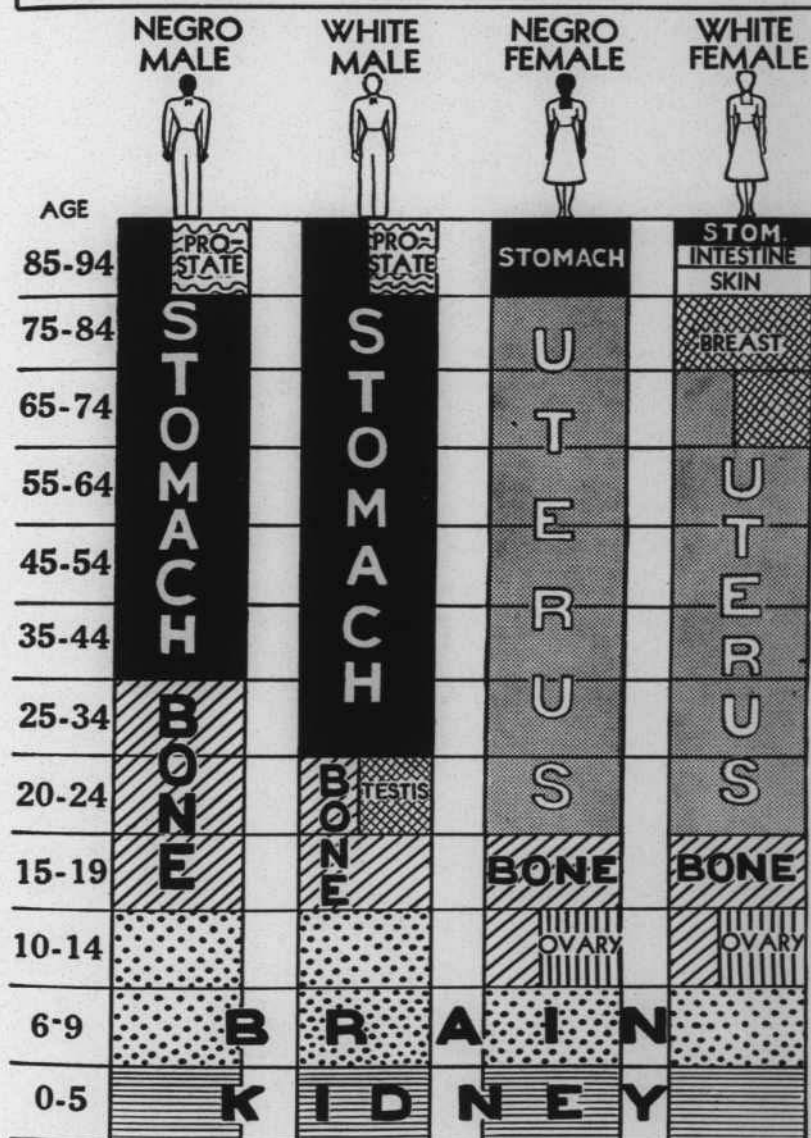
## TEN LEADING CAUSES OF RESIDENT DEATHS BY COLOR, FLORIDA, 1943

Rank	Cause	Total	White	Colored
1.	Heart disease (All Forms)	4,998	3,927	1,071
2.	Cerebral hemorrhage	2,073	1,278	795
3.	CANCER (All Forms)	2,032	1,677	355
4.	Nephritis (All Forms)	1,607	1,022	585
5.	Pneumonia (All Forms)	1,067	611	456
6.	Air-transport accidents	969	967	2
7.	Tuberculosis (All Forms)	842	366	476
8.	Premature births	680	486	194
9.	Automobile accidents	481	362	119
10.	Diabetes mellitus	405	326	79

Deaths from the above represent 65% of resident deaths from all causes.



# Where Cancer Hits



# FIVE LEADING CAUSES OF RESIDENT DEATHS BY CERTAIN AGE GROUPS FLORIDA, 1943

	No. of Deaths	Per Cent of Causes
<b>15-24 Years</b>		
All causes	1,680	100.0
Air-transport accidents	710	42.3
Tuberculosis (all forms)	106	6.3
Automobile accidents	93	5.5
Homicides	68	4.0
Puerperal state	60	3.6
Other causes	643	38.3
<b>25-44 Years</b>		
All causes	3,692	100.0
Heart disease (all forms)	485	13.1
Tuberculosis (all forms)	372	10.1
Air-transport accidents	247	6.7
<b>CANCER</b> (all forms)	233	6.3
Homicides	207	5.6
Other causes	2,148	58.2
<b>45-64 Years</b>		
All causes	6,448	100.0
Heart disease (all forms)	1,712	26.5
<b>CANCER</b> (all forms)	881	13.7
Cerebral hemorrhage	797	12.4
Nephritis (all forms)	534	8.3
Pneumonia (all forms)	242	3.7
Other causes	2,282	35.4
<b>65 Years and over</b>		
All causes	8,451	100.0
Heart disease (all forms)	2,714	32.1
Cerebral hemorrhage	1,087	12.8
<b>CANCER</b> (all forms)	887	10.5
Nephritis (all forms)	878	10.4
Pneumonia (all forms)	327	3.9
Other causes	2,558	30.3

## IS CANCER ACTUALLY INCREASING? (Continued from Page 57)

Finally we must realize that these conditions which we call cancer are not new; they are as old as the human race. Man as he is today has existed, we are told, for some 25,000 years. Cancer has been in existence for several thousands of those years, it has been found in Egyptian mummies, and it is mentioned in the Bible as well as in ancient Indian writings.

Considering these facts it is evident we are not justified in saying that the human race has suddenly become more susceptible to cancerous diseases. Rather, it would seem that through advanced medical knowledge and more scientific methods we are now recognizing as cancer many conditions formerly overlooked.

# DEATHS FROM CERTAIN CAUSES BY COUNTIES FOR TWELVE MONTHS FLORIDA, 1944

All figures for the current year are "Provisional"

Popu- lation*	Counties	Typhoid	Diph- theria	Tuber- culosis	Malaria	Cancer	Pell- agra	Fuer- peral	Motor Vehicle	All Ac- cidents
1,911,998	STATE	13	41	795	31	2,171	36	161	550	2,580
38,724	Alachua	1	0	17	2	37	1	7	7	29
6,510	Baker	0	0	0	1	1	0	0	1	1
20,885	Bay	0	2	3	3	9	0	3	14	75
8,717	Bradford	0	0	3	0	5	0	1	1	5
16,226	Brevard	0	0	4	0	14	0	1	11	61
40,637	Broward	2	0	16	0	56	0	4	16	91
8,218	Calhoun	2	0	1	0	2	0	0	0	5
3,663	Charlotte	0	0	2	0	2	0	0	0	11
5,860	Citrus	0	0	2	0	2	0	0	1	6
6,468	Clay	0	1	5	0	8	0	0	6	52
5,118	Collier	0	0	0	0	1	0	0	6	16
16,939	Columbia	2	2	12	0	49	0	9	11	35
272,116	Dade	0	3	145	0	344	2	18	75	244
7,792	DeSoto	0	1	3	0	10	0	2	0	4
7,080	Dixie	0	0	4	1	2	0	1	1	8
211,946	Duval	0	6	143	3	231	4	14	74	311
75,584	Escambia	1	4	30	0	84	3	9	40	122
3,008	Flagler	0	0	0	0	0	0	1	1	12
5,991	Franklin	0	1	0	0	1	0	1	3	13
26,952	Gadsden (ex.)	1	0	2	2	23	2	3	7	24
5,176	State Hosp.	0	0	46	0	15	0	0	0	8
4,252	Gilchrist	0	0	1	0	0	0	0	1	3
2,749	Glades	0	0	0	0	0	0	0	0	1
7,147	Gulf	0	0	0	0	3	0	0	0	6
9,781	Hamilton	0	0	2	0	4	0	0	1	5
10,158	Hardee	0	0	0	0	12	0	1	2	6
5,312	Hendry	0	0	0	0	0	0	1	0	5
5,651	Hernando	0	0	0	0	1	0	1	5	28
9,246	Highlands	0	1	3	0	9	0	1	0	26
181,237	Hillsborough	0	4	90	0	259	2	16	46	193
15,499	Holmes	1	0	2	1	3	0	0	3	10
8,983	Indian River	0	0	2	0	0	0	1	3	32
34,428	Jackson	0	2	7	0	9	0	6	7	29
12,032	Jefferson	0	0	1	0	6	0	2	4	10
4,413	Lafayette	0	0	0	0	3	0	1	0	2
27,255	Lake	0	0	8	0	39	0	3	4	21
17,547	Lee	0	0	4	0	24	0	2	9	48
31,904	Leon	0	0	4	1	13	2	5	14	38
12,550	Levy	0	1	1	3	7	1	1	2	9
3,752	Liberty	0	0	0	0	1	0	0	1	7
16,190	Madison	0	0	6	1	6	0	2	2	10
26,255	Manatee	0	4	8	0	34	0	0	2	43
31,272	Marion	0	1	11	1	35	2	2	13	36
6,347	Martin	0	0	2	0	5	0	0	1	11
14,117	Monroe	0	0	6	1	21	0	1	2	69
10,911	Nassau	0	0	1	1	9	0	1	6	24
12,966	Okaloosa	0	1	2	0	8	0	2	6	40
3,000	Okeechobee	0	0	1	0	2	0	0	1	13
70,311	Orange (ex.)	0	0	28	0	94	1	3	15	81
308	St. T.B. Hosp.	0	0	40	0	0	0	0	0	0
10,137	Osceola	0	0	3	1	9	1	1	4	21
81,348	Palm Beach	0	1	25	1	90	0	6	26	91
14,119	Pasco	0	0	2	1	15	0	0	3	14
93,226	Pinellas	1	0	31	2	243	2	4	17	77
86,903	Polk	1	3	15	0	86	4	4	22	109
18,720	Putnam	0	1	7	0	23	0	2	5	25
20,135	St. Johns	0	0	7	0	25	0	1	10	33
12,015	St. Lucie	0	0	3	0	10	1	3	2	20
16,117	Santa Rosa	0	0	1	0	11	0	0	1	12
16,223	Sarasota	0	0	5	0	28	0	3	4	36
22,313	Seminole	0	0	5	0	21	2	2	5	32
11,092	Sumter	0	0	0	0	7	0	1	2	9
17,080	Suwannee	0	1	4	1	6	1	2	4	8
11,591	Taylor	0	0	1	0	5	1	0	0	13
7,094	Union	0	0	3	0	4	0	1	2	12
53,874	Volusia	1	0	13	4	62	3	4	11	98
5,463	Wakulla	0	0	0	0	2	0	0	1	11
14,269	Walton	0	1	2	0	11	1	1	4	13
12,302	Washington	0	0	0	0	10	0	0	1	7

\*Estimated population July 1, 1940.

From Federal Census April 1, 1940.

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## *Florida* **HEALTH NOTES**

PUBLISHED BY THE FLORIDA STATE BOARD OF HEALTH

JACKSONVILLE • MAY, 1945 • VOL. 37 • No. 5

NUTRITION SURVEY NUMBER



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# Florida HEALTH NOTES

ESTABLISHED 1890

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## ACRES OF NUTRITION

For all our talk about nutrition, how well do we eat? Our children's eating practices often reflect our own. How well do our children eat?

A Nutrition Survey was conducted this year in seven representative Florida counties. An examination of over 2,000 school children was made. Although only this small fraction of Florida's total population was reached, the number examined was large enough and so geographically spaced to be definitely indicative. The Survey and findings are summarized in this issue of Health Notes.

Rather than expressing gratitude in mere words to the professional men and women who conducted this valuable survey, we would all do better to prove our appreciation by eating regularly the good foods they so reliably recommend.

For Florida, too, it seems, has her "acres of diamonds." Nutritionally speaking, our very own back yards hold acres of good living—acres and acres of nutrient-rich fruits, vegetables, and a wealth of other good foods that we Floridians too often fail to place upon our tables!

Every home, hamlet, county or state is basically only as strong as its people. May Florida continue her forward strides to build wisely and well an ever stronger, ever healthier people, upon whom rests her power as a State. Let us ALL eat our just and needed share of the fine foods we produce.

---

The young man enjoying the glass of orange juice wasn't "sitting" for his picture. He just happened to look up, and the camera went off right in his face. Note particularly the orange juice, pride of the East Marion School cafeteria. "All the juice you can drink" is served every day with lunch, no extra cost. Incidentally, Dr. Gates was speculating about the splendid condition of the children's gums at East Marion until she ate lunch in the cafeteria. The orange juice was the answer. (Staff photo).

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# A FLORIDA NUTRITION SURVEY

By **EMILY H. GATES, M. D.**, *Assistant Director*  
*Bureau of Maternal and Child Health,*  
*State Board of Health, Jacksonville*

## PURPOSE AND METHODS OF EXAMINATION

In January of this year Florida was fortunate to have as a visitor Walter Wilkins, Surgeon (R), United States Public Health Service. Many Floridians had already become nutrition-conscious through reading and following the booklet "Nutrition for You," of which Dr. Wilkins is co-author. The booklet\* tells briefly and clearly many of the danger signals of malnutrition and shows how they may be avoided or corrected by satisfactory eating practices.

The purpose of Dr. Wilkins' visit to Florida was to help us learn more about what Florida children are eating, to determine the prevalence of various nutritional deficiencies, and to point the way toward correcting them. To achieve this purpose a Nutrition Survey was begun with the cooperation of local health units, school personnel and other interested groups.

During a period of several weeks approximately 1,000 school children in five widely scattered Florida counties were examined for signs suggestive of malnutrition. Of this group 75% were white children, 25% Negroes. Although slightly less than one-fourth of the youngsters attended rural schools undoubtedly the home surroundings of nearly one-half could be considered rural.

It is common knowledge that a certain type of rash is usually a sign of measles. Just so, there are certain other readily observable physical findings which are usually signs of specific deficiency conditions. Each child was given a brief examination designed to find these signs if they were present and to grade them according to severity.

Vitamin A deficiency is often associated with a granulated condition of the eyelids and a peculiar bumpiness or scaliness of the skin. Therefore eyes and skin, particularly of the arms and legs, were examined.

\*Available free from the Bureau of Maternal and Child Health.



It is needless to say that both young men in this picture received the coveted Zero rating in the nutritional survey conducted at Oneco School, Manatee, by Dr. Gates and Miss Morrison. Ratings begin with zero and range upward as more and more defects rear their ugly heads. Assisting Dr. Gates is Miss Irene Fitzgerald, Manatee County Nurse. (Staff photo).

Mouths were inspected for scarring or actual sores at the corners, and eyelids examined for crusting along their margins. Both of these signs often occur in persons whose diet is lacking in Vitamin B<sub>2</sub>.

Tender, spongy gums which may bleed easily are frequently danger signs of Vitamin C deficiency. Gums were checked for signs of this deficiency which in its more serious forms is known as scurvy.

Heads, chest and knees were examined for superficial signs suggesting rickets, past or present. One cannot say specifically that these mean a lack of the "sunshine vitamin," Vitamin D, alone. Lack of other substances such as calcium or phosphorus may also be involved. Consultation with parents, however, usually revealed that little or no cod liver oil or other source of Vitamin D had been given to supplement the Vitamin D which the skin itself forms when exposed directly to sunlight.

Anemia exists when the hemoglobin or red portion of the blood falls below a certain level. Nutritionally this may be due to lack of iron, protein, Vitamins B or C—any one or all of these. To determine whether or not the children were anemic, blood hemoglobin tests were made whenever possible.

Hookworm testing was carried out by means of laboratory examination of stool specimens. No person infested with hookworms can experience the best possible health. Regardless of adequate diet, he will likely develop anemia and often other deficiency conditions.

This describes in general the type of examination instituted by Dr. Wilkins during the weeks he was in Florida. In areas where the Survey was conducted assemblies of parents, teachers and other interested groups were held so that those attending would have an opportunity to observe various deficiency conditions at first hand and learn how they can best be prevented by proper eating.

A particularly gratifying aspect of the Survey was the interest manifested by the children themselves. They seemed willing to overcome dislikes for this food or that when told it would help them get rid of swollen gums, roughened skin, granulated lids or other danger signs. As the children develop a greater awareness of their nutritional needs, whole families will tend to acquire better eating practices and thereby improve their general health. This at least has been the hope of those associated with the Nutrition Survey.





Here Dr. Gates is hard on the trail of a granulated-type condition of the eyelids which manifests itself with Vitamin B deficiencies. Giving her a hand is Harold Hathoway, principal of Oneco School, Manatee County. (Staff photo).

## SUMMARY OF NUTRITION SURVEY FINDINGS

Since January the Nutrition Survey begun by Dr. Wilkins has been expanded to include over 2,000 children. Examinations have been made in seven counties, giving fair representation to all sections of Florida. The group was quite evenly distributed between rural and urban schools. One-fourth were Negroes. Children in grades 1 through 12 were examined, but the majority were in the lower 6 grades. Of the 2,000 examined, approximately one-half had blood hemoglobin tests, and hookworm tests were reported for one-third.

Although 2,000 children are only a small fraction of Florida's school population, they constitute a large enough group to indicate definite trends.

One becomes acutely aware that hookworm infestation is still a major problem when faced with the fact that 31.4% of all specimens tested for hookworm were found to be positive. The lowest rate found in any school where reports were available was 5.3%. In one small rural school 18 out of 20 children tested were found to have hookworms! Is it to be wondered that in that particular school 69.2% of the students tested were anemic according to our standard?

We are prone to think of hookworms as most prevalent in rural areas where sanitary conditions are not the best. Nevertheless, 46 of the 104 students examined in one city school were hookworm positive. Much has been accomplished in the effort to eradicate these parasites. Obviously much still remains to be done. Proper diet can help youngsters combat the devitalizing effects of hookworm infestation—but children can never receive full benefit from their food while their bodies remain hosts to hookworms.

Many of the children who had blood hemoglobin tests were found to be well above the anemia level—but not all. The Negro children in general were found to have lower hemoglobin levels than white children in the same area. In one Negro school 95.8% of the students were anemic according to our standards.

In one white school where 50% of the children had hemoglobin tests above 83% (13.3 Grams) three children in one family had hemoglobins of 51%, 44%, and 33% (8.1, 6.8, and 5.1 Grams). The highest of these three ratings equalled only two-thirds of the median for that particular school. It is surprising that these children were even in school. No wonder one of them sat with his head lying on his desk and ignored the classwork going on about him. Surely his extreme anemia helps to account for the fact that he is only in the third grade, though 10 years old.

In spite of the abundant sunshine which helps the body manufacture its own Vitamin D, there were areas in which well over 50% of the children had at least slight signs suggesting rickets. It is an established fact that certain children require larger amounts of vitamins than other children. Our findings seem to indicate that to be on the safe side all children should be given supplementary Vitamin D in the form of cod liver oil or similar products. This appears to be particularly true among the Negroes, in whom signs of rickets were most prevalent.

In some areas we found a significant percentage of children with signs suggestive of Vitamin B<sub>2</sub> deficiency. Investigation of their food practices indicated that these children failed to get enough milk as a source of this vitamin. This condition was more common in rural areas than in the cities. Many of the boys and girls told us they could have milk for the asking, but "just didn't drink it." It is unfortunate that growing children anywhere are allowed to ignore this nearly complete food.

There were some who showed indications of lack of Vitamin C, even here in Florida where some source of Vitamin C could be grown in every yard or garden patch. In one isolated rural area 60% of the children had gum signs of Vitamin C deficiency. Fresh fruits and vegetables must be scarce, indeed, in the dietary of children with such conditions. In this same school there were two cases of mild but very real pellagra, due to lack of Vitamin B.

Causes of these deficiency conditions vary. Many, many folks—children and adults—don't care whether or not they eat the right kinds and amounts of food because they do not see the relationship that may exist between certain unwanted physical conditions and dietary deficiencies. Many don't realize how much better off they might be through the years were their day-by-day eating practices sound. Many do not know what foods constitute an adequate diet. Many mothers do not prepare meals so that food values are preserved. A great number are unwilling to change long-standing eating customs even when they have "learned better." It is true that certain recommended foods are not too plentiful these days and many folks do not know that substitutes can often be secured to supply the needed food values. Some persons are not economically able to secure all foods recommended daily. Here again, home gardening and home food production, wise buying, knowledge and use of adequate substitutes and careful planning should enable folks in even the lowest income groups to eat far more adequately than they do.

Dr. Gates gives this youngster a closer-than-usual going over in her search for mild nutritional deficiencies among school children. Texture of the skin, bone formation, condition of eyelids, teeth and gums are some of the physical points demanding scrutiny in the survey because they are first in showing signs of an inadequate diet. (Picture was made at Oneco School, Manatee County). (Staff photo).



It is not the purpose of this article to imply that Florida's children are generally malnourished. That would not be true. It is our purpose to present the facts as we have found them, because we feel you want to know them. Whatever the underlying causes may be, too many of Florida's children are not properly nourished. This should not be true in a land where most essential foods can be grown so abundantly.

**RATE OF INCIDENCE OF SIGNS SUGGESTING VITAMIN DEFICIENCY AMONG 2,000 SCHOOL CHILDREN IN FLORIDA, 1945**

Sign Suggestive of Deficiency	Crusty Eyelids	Granulated Eyelids	Scarring & Sores at Corners of Mouth	Swollen, Spongy, or Bleeding Gums	Rough or Scaling Skin	Head, Chest or Knee Signs of Rickets
Vitamin	B <sub>2</sub>	A	B <sub>2</sub>	C	A	D
Highest rate found in any school	24.0%	52.0%	85.7%	60.0%	64.0%	93.7%
Lowest rate found in any school	0%	13.0%	0%	1.2%	12.5%	12.5%

## WHAT ARE FLORIDA SCHOOL CHILDREN EATING?

By **MARJORIE MORRISON**, *Associate Nutritionist,  
Bureau of Maternal and Child Health,  
State Board of Health, Jacksonville*

During January, 1945, dietaries were collected from school children in four areas of the State in connection with the Nutrition Survey. 95.7% of the children who recorded the foods eaten were white, 4.3% were colored. Together they represent every economic level found in Florida. The 321 children furnished a total of 668 daily dietaries, or food lists. Percentages quoted in this article and in the chart on page 82 are based on the total number of daily dietaries and not upon the number of children participating.

Since the food lists submitted were not accurate as to size of servings, they were checked only to see whether or not they contained certain foods, regardless of amounts. The diet records, therefore, indicate only general trends.

**Only 64.3% of the diet lists showed that a green or yellow vegetable was eaten during the day.** Since we count on green and yellow vegetables and fruits to furnish most of the Vitamin A in the diet, it is not surprising that many cases of granulated eyelids and folliculosis were found.

Here in Florida where all forms of greens—mustard, turnips and collards—and green beans, sweet potatoes, squash, pumpkin and carrots are raised easily, it is certainly



Miss Marjorie Morrison, recent acquisition to the nutrition staff of the State Board of Health's Bureau of Maternal and Child Health. Miss Morrison is a native Floridian (Hawthorne), a graduate of FSCW, with a Masters degree in nutrition and public health from the University of Tennessee. (Staff photo).





Martha King, principal of Prospect School, Manatee County, is a staunch advocate of doing something about that empty feeling in the tummy which shows up around the middle of the morning and afternoon. Consequently, she and the youngsters take time out to eat raw carrots, apples or oranges every day. Mrs. King believes that they are killing several birds with one stone—relieving hunger, storing up some extra vitamins and developing long range appetites for these good foods. (Staff photo).

quite possible for all of us to have at least one serving of a green or yellow vegetable each day.

Vitamin C deficiencies, which are indicated by swollen, spongy, bleeding gums, were observed. The number of cases found was surprising, though understandable when one notes that **only 55.8% of the diets studied contained any rich food source of Vitamin C.** This vitamin is usually associated with citrus fruits. Other Florida foods which are good sources of this vitamin are raw cabbage, green peppers, tomatoes, strawberries, watermelon and guavas.

Milk, that most nearly perfect food of which a quart a day is recommended for each child, was also shown to be used far too little in the diets recorded. Not only does milk furnish protein and calcium for growth and bone building but some of the B-vitamins in addition. A good portion of the day's riboflavin, that member of the B-vitamin family which prevents sores and scarring at the angles of the mouth, usually comes from milk. Food lists showed that **only 48.5% of the diets contained 3 or more glasses of milk each day,** 25.1% recorded two glasses, 16.3% showed only one glass. That leaves 10.1% recording no milk. Milk is scarce in many places, it is true, but is it this scarce in Florida?

Milk alone will not furnish the protein needed for adequate growth. Other protein rich foods such as eggs, meat, dried peas and beans are necessary for building and repairing body tissue. **While 56.8% indicated two good sources of protein foods during the day, 27.9% showed only one good source and 15.3% showed none.** Now that meat is more scarce than it was in January, will this percentage rise?

It is interesting to note that children from the higher economic levels seemingly did not spend more on sundries than some of those from the lower levels. The liking for sweets was apparent—60.4% had candy, cake, pie or cookies during the day.

Many children go without one meal during the day, usually breakfast, of course. The breakfasts of many who do eat something in the morning are not substantial ones. This first meal of the day can do so much to help the child go off to school mentally alert that all of us should support the person who said, "If breakfast is a problem meal, don't give it up—solve it!"

We often hear it said that nutritional anemia is one of Florida's biggest problems. Comparing the lists of foods eaten with the foodstuffs suggested as necessary in combatting

nutritional anemia (protein, iron, Vitamin C and the B-vitamins) definite relationships can be seen.

These records seem to show that Florida's children need more adequate diets before they can enjoy the maximum health which is justly theirs. The school lunch program is doing much to improve the situation. What can YOU do? YOU can help to convince parents, teachers, students, farm families, city families—all folks in all walks of life—that eating the right foods in the right amounts DOES make a difference.

Each of us can pass along to others the ways and means for securing, conserving and preparing needed foods. Above all, each of us can see to it that we, personally, and others

#### EAT THESE FOODS EVERY DAY:

- 1 serving green or yellow vegetable
- 1 serving citrus fruit, raw cabbage or tomatoes
- 2 other fruits or vegetables
- 1 quart milk (1 pt. for adults)
- 1 egg (3 or 4 per week for adults)
- 1 serving meat or meat alternate
- 4 servings of whole grain or enriched breads and cereals with butter or fortified margarine.

#### RECORD OF DIETARY SURVEYS MADE IN SEVERAL FLORIDA SCHOOLS, JANUARY, 1945

Bureau of Maternal and Child Health, Florida State Board of Health

	Number of children keeping records in each group		Number of days diets recorded by each group		FOODS RECORDED							
					Green or yellow vegetables	Citrus, raw cabbage, tomatoes	3 or more glasses of milk	2 glasses of milk	1 glass of milk	1 protein	2 proteins	Specified whole grain bread and cereal
Area 1	152	152	44	53	30	42	31	55	75	27	39	
* Area 2	15	15	10	3	1	2	5	9	3	2	5	
Area 3	39	39	31	15	17	7	10	6	31	6	27	
Area 4	115	462	345	302	276	117	63	117	271	27	333	
Total	321	668	430	373	324	168	109	187	380	62	404	
% Total			64.3	55.8	48.5	25.1	16.3	27.9	56.8	9.2	60.4	
* Negro												

Records of each food listed above indicate that some amount of that food was eaten during the day but the records do not necessarily indicate that the minimum daily requirement of that food was secured. Records on milk consumed are broken down to show approximate amounts, however. Percentages are based on the 668 daily dietaries rather than on the 321 total number of children who kept records.



Down in Manatee County, parents, teachers and members of the Oneco Community Club turned out for the demonstration clinic in connection with Dr. Gates' and Miss Morrison's Nutrition Survey. A number of school children with mild deficiencies volunteered to cooperate with the clinic in order that adults might more completely understand what physical signs were being looked for in the study—and why. It is hoped that information received during the clinics (others were held at Prospect and Samoset) will be helpful to mothers in preparing adequate meals for their families. On the long table, most of which is not in the picture, was a display of foods arranged in respect to their vitamin richness. (Staff photo).

---

Every morning the boys and girls in Miss Mabel Hager's class at Samoset School, Manatee County, get out their tooth brushes and paste, fill their glasses with water (each printed his own name on the label for his glass), and heigh for the backyard where they brush and brush and brush their teeth. Sometimes there's a great big hole in front, what with the Fairy getting all those teeth, but the brushing goes on just the same. Miss Hager teaches them to tackle the tooth problem from all angles; regular visits to the dentist, good nutrition and daily dental care. (See back page). (Staff photo).

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# *Florida* **HEALTH NOTES**

PUBLISHED BY THE FLORIDA STATE BOARD OF HEALTH

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*Malaria Research*  
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## **PUBLIC WATER SUPPLY**

The greatest single concern to any community is its water supply. In terms of capital investment, chemicals used and jobs created it can easily rank as the number one industry of the community. Water is basic. Without it the community cannot exist.

In the early days, our water was probably obtained from lakes, streams, and rivers. But as man progressed, he upset the balance of nature, in a sense. Sewage and industrial wastes polluted these waters. The value and quality of water consequently did not meet man's new demands. According to modern standards most of our surface waters are soft, highly colored, corrosive and of doubtful bacterial quality. Deep wells yielding artesian water came into use. These waters were normally sparkling clear but generally harder than desirable.

From the demands of public health and the desire for water of better quality came the construction of the modern filtration plant. Highly colored surface waters were coagulated for color removal and stabilized against corrosion. Hard ground waters were softened. Although Florida ranks twenty-seventh in population it ranks third in the number of gallons of water softened. In many respects we Floridians can be proud of our position in the field of water supply. But we cannot maintain that position unless we keep progressing. Several important suggestions concerning this progress are presented on the following pages of Health Notes.

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# FACING FLORIDA'S PROBLEMS OF PUBLIC WATER SUPPLY

by **J. B. MILLER**, *Chief Sanitary Engineer*  
*Bureau of Sanitary Engineering,*  
*State Board of Health, Jacksonville*

## SOURCES OF SUPPLY

Generally, there is an adequate supply of useable water in the State. In specific cases, however, this is not true, and unless careful planning is exercised the shortage can become serious. To mention only one instance, just recently the normal supply from wells in a community became inadequate and it was necessary to augment it with water of undesirable mineral quality.

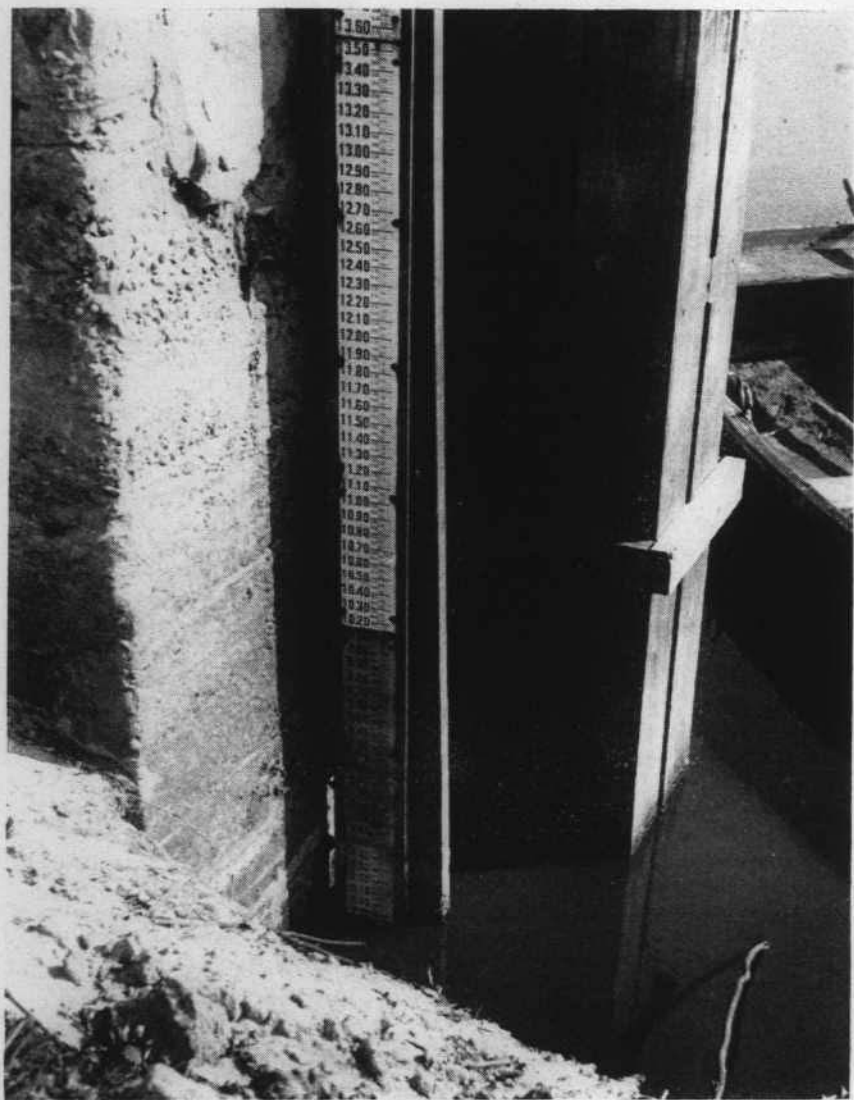
The key to the solution of adequate sources of water supply in Florida is two-fold:

- ★ **The intelligent conservation of water resources, and**
- ★ **Long-term planning on the part of municipalities, under the auspices of competent engineering advice.**

The discharge of inadequately treated sewage and industrial wastes into our waters is indeed folly.

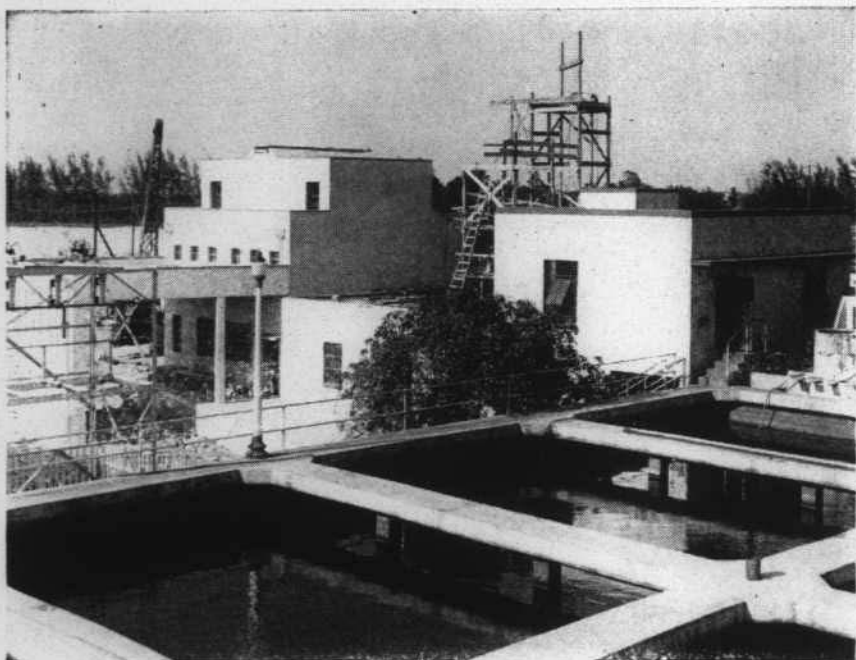
## QUALITY OF WATER

Every Florida town deserves a soft, sparkling clear, non-corrosive and safe water supply. The expenditure involved in securing this quality of water is well justified by the results obtained. When water is soft, laundry bills are reduced as are costs in hot water heater repair. Industries are attracted by a water supply of such quality. **Safe bacterial quality** is imperative. Some of these problems of water quality are still to be solved in many places in Florida.



Line on gauge pointing to 13.60 indicates normal water level of surface supply. However, because of acute drought and excessive pumpage, indicator now stands at 7.30 or five feet below normal. (Photo by courtesy of Smith & Gillespie, Architect Engineers, Jacksonville, Fla.)





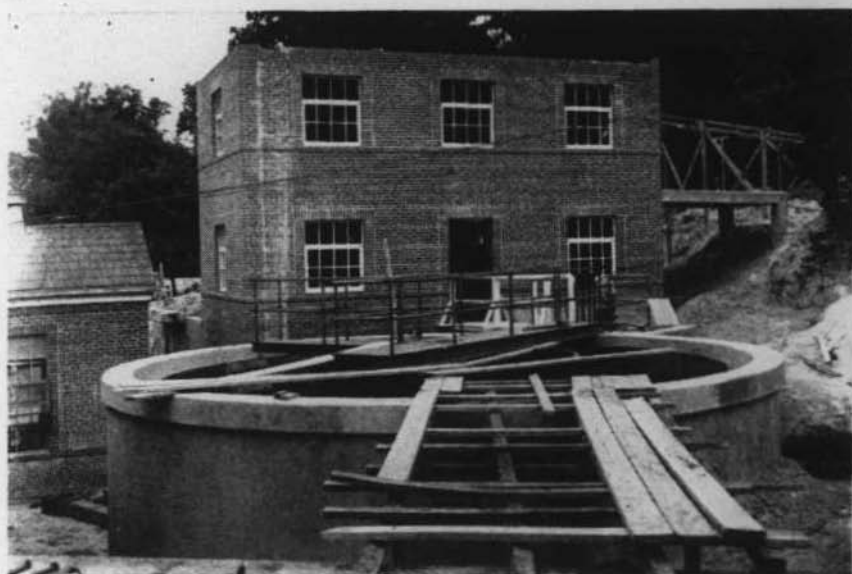
#### A SOLUTION TO DEFICIENCY OF NORMAL WATER SUPPLY

To offset the abnormally low water level, auxiliary hard water wells have been brought into use in some places. Above are new water softening units which have been added to a plant to make the water more usable. In background is chemical plant. (Photo by courtesy of Smith & Gillespie, Architect Engineers, Jacksonville, Fla.)

### CHLORINATION

Numerous queries and comments have been made concerning the chlorination of water throughout Florida during this time of war. Perhaps nothing has done more than chlorination to diminish water-borne diseases, except possibly filtration. Recent United States Public Health Service reports indicate faulty chlorination, or the lack of chlorination, to be responsible for the majority of enteric water-borne outbreaks throughout the country.

Man himself has polluted the streams and ground waters. Chlorination alone cannot be considered as a treatment process to purify all waters, certainly not in the dosages man can drink safely. Chlorination is a well justified **factor of safety**, not an overall solution. Efforts must be made to **prevent** the pollution of waters used for drinking.



In background is new two-story Lake City Water Works building, virtually ready for use as this goes to press. In foreground is the softening and clarification unit where chemicals will be added to water to remove color and hardness. Water then flows on to the filters shown, incomplete, in picture below where it drains through underdrains, gravel and sand . . . Water is then chlorinated and pumped to distribution system and thence to the city users. (Photos by courtesy of Russell & Azon, Consulting Engineers, Inc., Daytona Beach, Fla.)



## THE OPERATION OF WATER PLANTS

The urgency of public safety, continuous community demands, original expenditures on water treatment plants and the cost of their upkeep certainly justify the competent operation of such plants. One cannot expect competent operation unless efforts are made, financial and otherwise, to attract well qualified personnel with scientific training and ability for such operation responsibilities. The problem of qualified personnel is so important that it is given major emphasis in this discussion.

### THE WATERWORKS OPERATOR

Several years ago at a meeting of the Florida Public Health Association, Dr. Thomas Parran, Surgeon General of the United States Public Health Service, stated:

**"PERHAPS NO ONE HOLDS MORE RESPONSIBILITY INsofar AS THE HEALTH OF A COMMUNITY IS CONCERNED THAN DOES THE OPERATOR OF A PUBLIC WATER SUPPLY TREATMENT PLANT."**

The Florida State Board of Health, through its Bureau of Sanitary Engineering, is empowered by law to establish the qualifications for operators of water plants.

Recognizing the rapid and continuous improvement made in the field of water purification and the growing necessity for qualified men, and in an effort to encourage the employment of trained and experienced operators rather than untrained, inexperienced, or politically appointed operators, a plan was initiated in 1940 for the voluntary examination and certification of waterworks operators. At the same time the waterworks operators themselves formed the Florida Waterworks Operators' Association. The voluntary certification plan became a by-law of the Association.

Nothing in the text of the plan was to be construed as a compulsory measure and it was not necessary for any

operator to belong to any organization or association to qualify under the plan. All waterworks operators regularly employed in the pumping and treatment of domestic or industrial waters are eligible to apply for examination and certification. It was expected, however, that after a period of several years all waterworks operators in Florida would have obtained at least one of the grade certificates.

The Examining Board was established as a five-man board, one member being the Chief Engineer of the State Board of Health, another a member from the faculty of the University of Florida for coordinating the work of the Examining Board with the University's annual Short School given through its Extension Division. The other three members were to be elected by the Florida Waterworks Operators' Association so that insofar as possible the three men would be representative of the types of plants that exist in the state. Such distribution of the membership would make all applicants feel that there was someone on the Examining Board that understood the operation of their particular type of plant.

The Extension Division of the University of Florida was to be considered the training school for waterworks operators. Cooperation was to be given to the Extension Division by the Florida Section of the American Waterworks Association and the Florida State Board of Health.

Four types of certificates were to be issued, Class A, B, C, and D. Class D certificates qualify operators of water plants concerned only with pumping. The other certificates are for operators of water filtration plants. Qualifications necessary to obtain each of these certificates are outlined as follows:

#### **Class D Certificates**

The applicant taking the examination for a Class D certificate is expected to have specific knowledge of the procedures involved in operating and maintaining pumping plants where no treatment is involved. The knowledge expected of this type of operator is decided upon by the Examining Board with recognition of the fact that cases will vary because the pumps in some plants are electrically operated, in others diesel operated, while still others are operated with steam or gasoline.

### Class C Certificates

The applicant taking the examination for a Class C certificate is expected to have specific knowledge of the procedures involved in making fundamental bacteriological and common chemical tests and their application to plant control, an understanding of the significance of common physical and mechanical equipment in the plant and any other information deemed pertinent by the Examining Board.

Prior to being awarded a Class C certificate the applicant must present evidences of having had at least the following training and experience:

#### Training

#### Experience

Completion of Elementary School.....Six months

## FLORIDA WATER WORKS OPERATORS ASSOCIATION

ORGANIZED 1961

*This is to Certify that*

**Joe Waterman**

*Has qualified under all requirements of the constitution and by-laws of  
the association for*

### Class B

*certification and is entitled to all benefits thereof.*



CHIEF SANITARY ENGINEER STATE BOARD OF HEALTH

DATE \_\_\_\_\_

### Class B Certificates

The applicant taking the examination for a Class B certificate shall, as a matter of course, be expected to answer more highly specialized questions concerning water treatment and



plant operation than were asked in the examination for Class C certification. In addition to the specific subjects mentioned for the Class C examination, the candidate should have specific knowledge of coagulation, of chemicals used for coagulation, filtration, sterilization in all its phases, calculations for chemical dosages, filter rates, wash, water rates, causes of tastes and odors and their control, corrosion control, the keeping of plant records and reports, laws and regulations governing sanitation as applied to water supplies and any other information deemed necessary by the Examining Board.

Prior to being awarded a Class B certificate the applicant must present evidences of having had at least the following training and experience.

Training	Experience
Graduation from high school or more, and _____	6 years
or	
Graduation from high school with additional training in bacteriology and chemistry, and _____	4 years
Two years college with training in chemistry and bacteriology or public health, and _____	2 years
or	
Graduation from recognized college with technical degree, and _____	1 year
or	
One year Short School, and _____	4 years
or	
Two years Short School, and _____	3 years
or	
Three years Short School, and _____	2 years
or	
One year Short School, with college degree with major in chemistry or public health, and _____	1 year

### Class A Certificates

The applicants taking the examination for a Class A certificate are, as a matter of course, expected to have more information at hand covering the entire field of water supply and treatment than the candidates for Class B certificates.

To have specific knowledge of the chemistry involved in coagulation and sterilization, water softening, iron removal and corrosion control, the applicant should be able to calculate pump efficiencies and to make such use of hydraulics as would be generally used in water treatment.

The applicant shall be expected to have a general knowledge of the fundamental principles involved in the design of a water supply system, including source of supply, treatment plant and distribution system, as well as the maintenance of the physical and mechanical equipment involved and any other information deemed pertinent by the Examining Board.

Prior to being awarded a Class A certificate, the applicant must present evidences of having had at least the following training and experience:

Training	Experience
Graduation from high school or more, and.....	10 years
or	
Graduation from high school or more, with training in bacteriology and chemistry, and.....	8 years
or	
Two years college with additional training in bacteriology and chemistry or public health, and.....	6 years
or	
Graduation from recognized college with a technical degree, and .....	4 years
or	
One year Short School, and.....	8 years
or	
Two years Short School, and.....	7 years
or	
Three years Short School, and.....	6 years
or	
One year Short School with technical degree from recognized college, and .....	3 years

After fulfilling all requirements and passing the examination, applicants are issued a certificate of the proper class by the Florida Waterworks Operators' Association, which certificate is signed by the Chief Sanitary Engineer of the Florida State Board of Health, as chairman of the Examining Board. Other details of the plan are explained comprehensively in the original copy of the plan.



← A routine, but MUST job in a water works plant is checking chlorine residual in water before it is pumped into the mains for city consumption. The "residual" is excess chlorine, or the "left over" amount which has not been absorbed by the water. Here we have Ben Altman of the Jacksonville Water Works giving the current supply a last check with a Chlorine Comparator before it is released for city use. (Staff photo)

→ The oiling system of a water pumping engine is a delicate and tedious mechanism which must be checked regularly and often. (Staff photo)



← When Ben Altman of the Jacksonville Water Works plant starts the huge pump which can pump 12,000,000 gallons of water around the clock, he first makes certain that all is well with a half dozen gadgets before "giving her the juice." The wheel to the right is the throttle valve, and the contrivance at the left is another of the many intricate parts which must be in first class order if the giant engine is to supply Jacksonville's populace with water. (Staff photo)

The State Board of Health never has and never will attempt to interfere with home rule in any community. It has a responsibility to all citizens of Florida, however, which cannot be ignored. The American Waterworks Association has studied and observed very thoroughly the problems involved in the certification or licensing of water plant operators. On a national scale it has been proven that licensing plans are an equitable asset to both operators and municipalities. A licensing plan tends to strengthen and not weaken local civil service laws. It does not prohibit the appointment or dismissal of the waterworks employee, it merely establishes the standards and qualifications for competency.

Since the initiation of Florida's voluntary plan, a number of examinations have been held at either the annual Short School for Water and Sewage Treatment Plant Operators or at the Florida Section meeting of the American Waterworks Association. When it was impossible for an operator to attend either of these meetings, the examination was given under a city official in his own home town. The interest shown in this voluntary plan has been quite evident. At present twenty-two D certificates, twenty-five C certificates and thirteen B certificates have been issued.

When the plan was first advanced in Florida it was held by many that a compulsory licensing system for waterworks operators would become necessary eventually. It was felt that the voluntary approach was most sound in the beginning. More than sufficient time has been allowed for voluntary certification, however, and it is becoming increasingly clear that the moral and legal responsibilities of the State Board of Health will have to be assumed. Any waterworks operator who has not received his certificate can make arrangements for his examination by writing the Bureau of Sanitary Engineering. Before any compulsory licensing plan is established, however, it is important that all persons concerned make any suggestions they believe to be pertinent. And such suggestions are urgently invited.

The future of Florida's enviable place in the water supply field depends upon the clear, intelligent thinking of its people. Alert, civic-minded persons know of no subject which is more important nor one which deserves more serious consideration.

## PAMPHLETS, POSTERS AND FILMS ON SANITATION

Available free on request from the Bureau of Health Education, State Board of Health, Box 210, Jacksonville, Florida

PAMPHLETS . . . their original sources . . . their subjects . . .

Safe Water (U.S.P.H.S.)

Typhoid Fever (Metropolitan Life Insurance Company)

Water Supply in the Home (Bull. 104-E, Bureau of Sanitary Engineering, Florida State Board of Health)

From Hand to Mouth (U.S.P.H.S.) (For food handlers)

The Filthy Fly (Bull. 103-E, Bureau of Sanitary Engineering, Florida State Board of Health)

Malaria (U.S.P.H.S.)

Malaria (Metropolitan Life Insurance Company)

Malaria Quiz for Young Americans (U.S.P.H.S.)

Destroy Their Fox-holes (our own) (one page fly leaf showing chief breeding places of dengue fever-carrying mosquitoes)

Dengue and Yellow Fever (MCWA; U.S.P.H.S.) (one page fly leaf on breeding places)

Aedes Aegypti Mosquito Control (MCWA; U.S.P.H.S.) (instructions to Block Leaders)

Hookworm (our own)

The Sanitary Pit Privy (Bull. 102-E, Sanitary Engineering, Fla. State Board of Health)

Hookworm—How to Prevent It (Metropolitan Life Insurance Co.)

### POSTERS . . .

"Hookworm Bleeds the Life from a Man" (our own)

"Mosquito Proof Your Home" (U.S.P.H.S.) (series of five)

"Exterminate the Fly" (our own)

"For Our Patrons' Health" (U.S.P.H.S.) (Food handlers')

The two "wash hands" notices from Sanitary Engineering, Florida State Board of Health:

"All Employees Must Wash Hands Before Returning to Work"

"Stop! Wash Your Hands with Soap and Water"

"Don't Feed Rats" (U.S.P.H.S.)

### 16mm. FILMS . . .

#### General:

What Price Health (rural sanitation)

Defending the Cities' Health (urban sanitation)

Preventing the Spread of Disease

The House Fly

Keep 'Em Out (rat control)

#### Safe Water:

Health and the Cycle of Water

Every Drop a Safe One

#### Dengue and Yellow Fever Control:

Miss Keeter Goes to Town

Yellow Fever Mosquito

Aedes Aegypti Control

#### Food Handling:

Eating Out

Hand to Mouth

T'wixt the Cup and the Lip

Slinging Hash

Our Health In Your Hands (filmslides)

#### Malaria:

Winged Scourge (Walt Disney)

Mosquitoes and Malaria

Malaria Control

Lake County Mosquito Control

Mosquitoes

Singing and Stinging

SEE BACK COVER



## ANNOUNCING . . .

B'lieve it or not, after all these years, a NEW HOOKWORM FILM is on its way! A Walt Disney in technicolor, no less! The Office of Inter-American Affairs is making it and it's due in mid-July . . . Don't all rush at once!

Have you seen that good film on back-siphonage and other problems on plumbing, "The Ominous Arms Case"? It really holds interest for anyone, not just plumbers. We don't have it yet, but Mr. Richard Tait, president of The American Society of Sanitary Engineering, living at 700 N. E. 81st St., Miami 38, Fla., invites you to borrow their print.

Just received . . . Four new U.S.P.H.S. sound filmstrips, "Our Health in Your Hands," for use with Food Handlers' Schools . . . Lectures accompany each. Each filmstrip runs about ten to fifteen minutes. Here they are:

"Germs Take Pot Luck" . . . showing how germs cause disease and how they may spread, particularly in restaurants . . . how employees can help to protect public health . . . (76 frames)

"Service With a Smile" . . . emphasizing the need for food handlers to keep well and serve food in safe clean ways . . . (63 frames)

"In Hot Water" . . . How to wash, handle and store dishes correctly . . . hand dishwashing, step by step . . . the operation of a single-tank dishwashing machine . . . (75 frames)

"Safe Food for Good Health" . . . safe buying, safe preparation, safe serving of food . . . protecting it from contamination . . . (81 frames)



# *Florida* **HEALTH NOTES**

PUBLISHED BY THE FLORIDA STATE BOARD OF HEALTH

JACKSONVILLE • JULY-AUGUST, 1945 • VOL. 37 • No. 7, 8

**POLIOMYELITIS**

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Governor of Florida

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# Florida HEALTH NOTES

ESTABLISHED 1890

## MEDICAL DETECTIVES AND POLIOMYELITIS\*

The science and art of tracing a disease from one victim to the next, studying the cause and spread of preventable diseases throughout a community or a nation or the world, is known as epidemiology. The epidemiologist is the detective of preventable diseases. It is only when the details of the method and spread are known that effective control measures can be instituted.

When a child has been stricken with infantile paralysis, the illness is the result of a sequence of events. It is not enough to know that the disease is caused by a specific organism — the poliomyelitis virus. How did the virus enter the child's body? How was it carried from its last victim? What man, beast, insect or thing carried it? And what can be done to stop the same events from happening again and again? These are the questions which confront the epidemiologists.

During the more than one hundred years since infantile paralysis has been recognized as a separate disease, many ideas have been advanced and much work has been done, but not enough as yet to give the true answers. Men of science had to start with absolutely nothing more than the fact that year after year, in place after place, more and more cases were added to an already lengthy list.

But there are many clues which have been found and which when followed will ultimately lead to control. These are not clues to be followed by the amateur armchair detective. These clues will not lead into easy pathways, but rather they will call for many years of really hard work. It is to these scientists, to these laborers in epidemiology, to these medical detectives and their research that we must offer our fullest support.

\* From the pamphlet, "The Importance of Research", published by the National Foundation for Infantile Paralysis.

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# WHAT, PLEASE, IS THIS POLIO?

By **ELSIE D. WITHEY**, *Director of Health Education*  
in cooperation with

**E. F. HOFFMAN, M. D.**, *Director of Epidemiology,*  
*Florida State Board of Health, Jacksonville 1, Florida*

"Polio", of course, is a short way of saying poliomyelitis, or infantile paralysis. We all know that it is a dreaded disease, but all of us—you and I, every man, woman and child, rich or poor—all of us wish we knew more about it.

Some questions still pose before the great men and women of medicine and science, too. And many answers must still be found before the world can be freed of this disease. But much has been learned! Long and patient study has been made, is being made now, and will keep on being made by our scientists, driven with the knowledge that there **are** answers and that these answers **will** be found.

What are the clues, we wonder?

Doctor, do help us for a moment, will you? Tell us, first of all, if you will . . . **What is this "virus" that causes polio?**

"Well," slowly the concerned but determined voice of What-Is-Known-About-Polio speaks, "A virus is very very small," he tells us patiently. "It is something far too small to be seen even under the most powerful microscope. The polio virus is one of the smallest of the known viruses. And there are about fifteen different strains—or slightly different types—of polio viruses that we know about . . ."

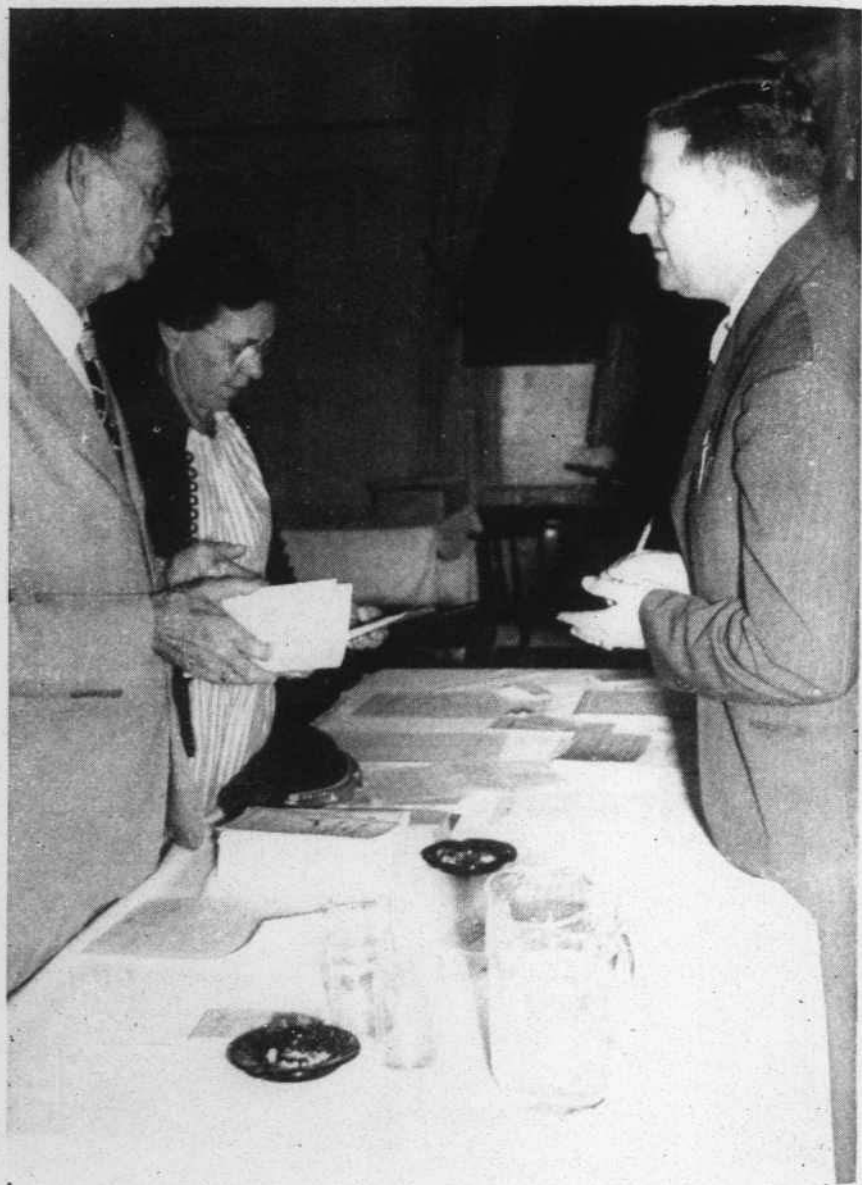
**"But what is it they call a 'filterable virus'?"** we ask, rather surprised at our own question.

"It is a virus that will pass through the finest of filters. The polio virus is a filterable virus," the Doctor explains.

**"But how can they get around if they're so small?"** we venture.

"Well, you see," he tells us, "they must depend upon the persons or things they infect to move them from place to place . . . Furthermore," he adds quickly, "they can't multiply except within the healthy living body cells of their host. And the polio virus can multiply in **only a few of the living cells of but very few animals.** Man, of course, seems to be their favorite host."





Mr. Marion T. Jeffries, Florida Representative of the National Foundation for Infantile Paralysis, discusses a point with two visitors during a break in the Jacksonville meeting for County Chapter Representatives. (Staff photo)

Then, because we might not understand, he adds, "We wish we knew just exactly where these viruses are or could be. For they do exist outside of the human body. They withstand drying, many antiseptics and germicides, and very low temperatures, but they have never been grown in a test tube, nor have they been known to multiply or cause damage outside of certain living cells."

"They really seem to know some of the answers about this virus, don't they, Doctor?"

"Well, yes, the polio virus is fairly well understood by the scientists. There is much yet to learn about it, but we do know that **this virus does cause polio**. It must be spread from person to person to produce infection. Without it infantile paralysis does not occur and nothing else has been discovered as the cause of infantile paralysis!"

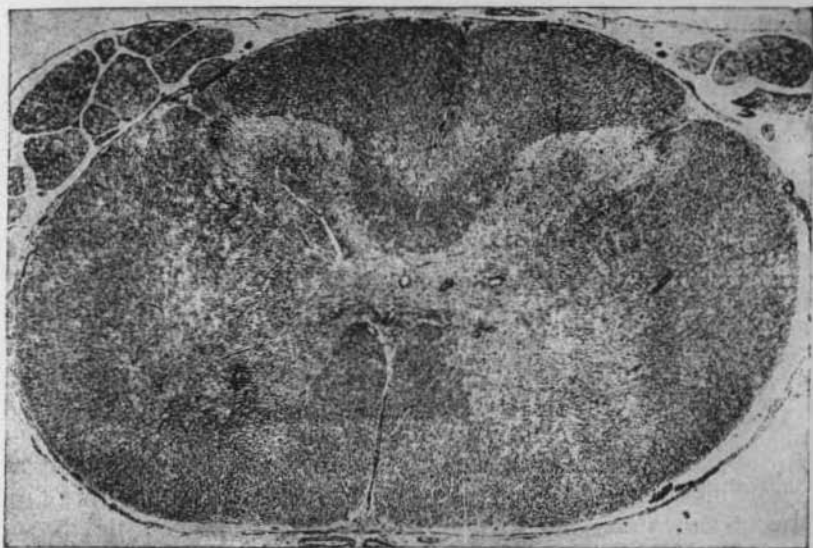
That sounds pretty definite, we think, and figuring we are putting two and two together rather smugly, we conclude, "Then this virus can exist in many places, perhaps, but every time it gets into the human body and reaches certain cells it begins to multiply and that person gets polio . . . gets this paralysis?"

"Oh, no! That's where you're wrong!" The Doctor was emphatic. Evidently our two and two made nine, or something except four! "Too many people believe that this paralysis is the sign of polio. **The baffling fact is that many, many people may be infected with the polio virus who never develop paralysis!** Why, for every patient who has some degree of paralysis there may be fifty or even a hundred or more persons so mildly infected with the polio virus that they never develop paralysis and never suspect they have it! Some cases, too, are so severely and overwhelmingly infected they die before paralysis has time to develop."

My, put the plot thickens! "**But how can this virus affect different people so differently, Doctor?**" we ask, amazed.

"That we can't tell, exactly. Once the virus enters the body it may do one of several things. Some people seem to have developed a resistance or an immunity, although there is no way of telling who these persons are. This may be largely due to a previous mild attack of non-paralyzing, unrecognized polio or to repeated exposures to the virus in doses too small to produce infection. On the other hand, other per-

sons' bodies may prove to be fertile fields for the virus, allowing it to grow rapidly and to spread over many parts of the body, causing great damage or even death. And it may strike with all degrees of difference between these two extremes. Most reported cases," he continues, "occur in younger children. This age group has not yet lived long enough to come in contact with small doses of the virus."



A cross section of the spinal cord. It is in the upper part of the butterfly-shaped central portion that nerves controlling motion are to be found. It is here that the virus does its greatest damage. (Magnified 20 times). (Courtesy National Foundation for Infantile Paralysis, "The Importance of Research.")

### "Where does the virus go in the body?"

"You still want me to keep on?" The Doctor smiles rather knowingly at our wide-eyed interest. We nod emphatically and he senses that we mean business. "The virus," he begins again, "apparently finds in the human body two favorite locations for growth . . . the intestines and the nervous system. As it grows in the intestinal canal it produces only mild symptoms. Slight fever, headache; possibly nausea, vomiting and diarrhea may occur. These symptoms last for a few days. They may mean nothing or they may be the forerunners of a more serious stage of the disease."

"Doctor," we are really concerned, "do you mean that during an outbreak, for example, for every paralyzed person there are **many** such mild cases? Cases that may never come to a doctor's attention? . . . People that don't suspect . . . don't know about it themselves?"

"Unfortunately, that's true," he tells us, "and these persons can't avoid spreading the disease, even if they do so innocently. These mild cases, so called, are very serious from the public health point of view because they are undoubtedly responsible for spreading the disease far and wide. And there is no practical way to find out who these persons are. Often the virus can be recovered from their stools, but only after long and expensive laboratory work."

"They are just like carriers, then?"

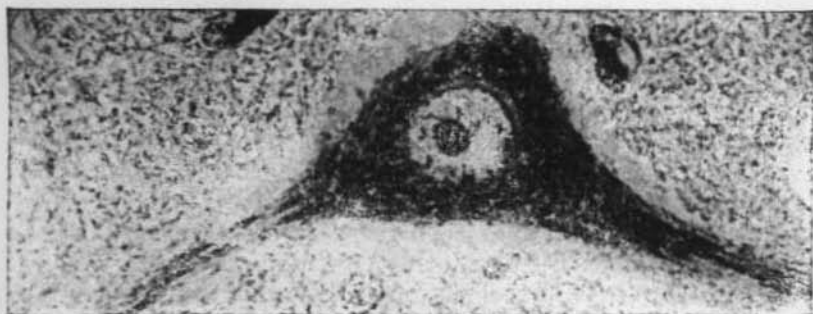
"They are carriers, without question."

"This, then, may account for the few far scattered cases that seemingly arise out of nowhere?"

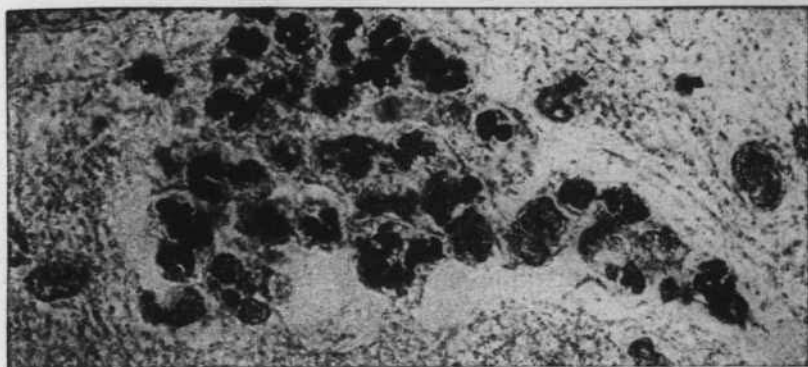
"Quite possibly. That is certainly our belief."

"What happens in the more severe cases, Doctor?"

"In relatively few persons, for some reason also unknown, the virus after being in the intestinal canal invades the nervous system. It seems as if the nervous systems of **just a few of the many persons infected** prove to be 'fertile hunting grounds' for the virus. We don't know why. But in these **comparatively** few persons, the virus, on leaving the intestine, supposedly travels along the nerves to the spinal cord and brain.



A normal nerve cell (magnified 1,000 times). (Courtesy, National Foundation for Infantile Paralysis, "The Importance of Research.")



A nerve cell destroyed by the poliomyelitis virus.

As it follows these pathways it does apparently little harm until it reaches certain **nerve cells** which are better suited for its growth and multiplication. When it reaches these nerve cells it multiplies rapidly, causing the dangerous and serious symptoms. Then there are symptoms of pain, stiffness of the muscles and loss of motion."

"But does the virus also live on the muscles?"

we wonder.

"The infantile paralysis virus lives upon and damages nerve cells and nerve cell endings, upsetting our bodies' complex balance of nerve-muscle action. The virus apparently does not affect the muscles directly nor does it grow in the muscle cells."

"What does the virus do to the nerve cells?"

"If nerve cells have been only slightly damaged due to the swelling of the surrounding tissues they may fully recover after this swelling has subsided and the symptoms disappear. On the other hand, if a few cells have been killed others in time learn to take up the functions of those destroyed. Under these circumstances, if proper treatment and re-education therapy are instituted, the use of these muscles or groups of muscles may be completely regained."

"Can nerve cells be replaced?" we ask.

"Once the nerve cell dies it cannot be replaced."



**"What about the paralysis, Doctor?"**

"When there is extensive damage from the virus to the cells of the spinal cord there is bound to be paralysis. This may be permanent in nature. Only orthopedic surgery, braces and other mechanical measures can then help to restore some degree of use to the crippled parts."

The answers to these questions seem only to lead to more and more questions. We just cannot help asking...

**"How, please, does the virus spread from one person to another?"**

"Now that," he chuckles, "is the one million and sixty-four dollar question, to be sure! And I'd be worth that much, too, if I knew the answer!" he grinned. "But here is what is known about it. It is known that the virus is passed out of the body through the bowel discharges of apparently every patient, no matter how mild the disease. It is known that many persons in contact with these cases, mild or severe, will also have the virus in their stools, many being carriers for months. Sewage, privies, rivers polluted with sewage all have yielded the virus when modern laboratory methods are employed. Flies trapped in homes where polio cases exist may be laden with virus, as may flies trapped far from these homes during epidemic times."

**"Well, Doctor, what can we do?"** The inevitable question . . . what precautions can be taken?

"There is no known prevention or protection against infantile paralysis as yet, of course . . . But it is only logical that everyone is much safer when following the sound everyday health practices which help to keep body resistance high and which permit only a minimum of infectious organisms to enter the body. These practices, for example, should be carefully observed by all . . .

**AVOID UNNECESSARY CONTACT WITH OTHERS.** Prevent children coming in close contact with new groups of people during a polio outbreak. The fewer the contacts the less chance of being infected. Rigid confinement of a child to his home, however, will not always prevent his contracting the disease.

**PAY CAREFUL ATTENTION TO PERSONAL CLEANLINESS,** such as thorough handwashing before eating and after using the toilet. See that children and all other members of the household take nothing into their mouths that could have been soiled by the discharge from the bodies of others.

**USE THE PUREST MILK AND WATER YOU CAN.** Keep flies away from food. Contaminated water and milk are always dangerous and flies have repeatedly been shown to carry the polio virus. Screen the house against flies and mosquitoes.

**KEEP BODY RESISTANCE HIGH—AVOID OVERTIRING AND EXTREME FATIGUE** from strenuous exercise. Avoid sudden chilling.

**AVOID TONSIL AND ADENOID OPERATIONS DURING EPIDEMICS.** During epidemics such operations tend to increase the danger of contracting infantile paralysis in its most serious form.

**KEEP COMMUNITY SANITATION AT A HIGH LEVEL AT ALL TIMES.**

Swimming, in itself, is not thought to be harmful, but if the water is contaminated by sewage or human pollution a definite danger is present. Also, if the child meets new people and is exposed to new crowds during an outbreak, then swimming may be a menace even though the water itself is safe. Little is gained, however, if the child is not allowed to go swimming but is permitted to mingle with crowds of people on the streets, in stores and other common meeting places.

**FOLLOW THE DIRECTIONS OF YOUR HEALTH OFFICER.**

Hard and fast rules cannot be formulated relative to attendance at schools. In a city the child actually makes fewer new and intimate contacts in school than out of school. Keeping children out of school will not help much if they are permitted to come in contact with crowds elsewhere. Your local and state health officers are well qualified to decide this issue on the basis of local considerations. Follow their advice."

### **DURING AN OUTBREAK—**

**Do not become hysterical.** Although this is a frightful disease, needless fear and panic only cause more trouble.

**Be alert to any early signs of illness or change in normal health, especially in children.** Do not assume that a stomach upset with vomiting, constipation, diarrhea, severe headache or signs of a cold and fever are of no importance. All children and adults sick with unexplained fever should be put to bed and kept away from others until the doctor has seen them and given directions to be followed.

**Call the doctor without delay.** Expert medical care given early may prevent many crippling deformities.

## NOTES ON THE FLORIDA MEETING OF INFANTILE PARALYSIS

Problems of infantile paralysis were discussed at length at two meetings in Jacksonville on June 27th and 28th this year under the conference leadership of Dr. John L. Lavan, Director of Research of the National Foundation for Infantile Paralysis. Meetings on the first day were held in the library of the Florida State Board of Health where, in addition to Dr. Lavan, the following participated:

Dr. Henry Hanson, State Health Officer.

Bureau Directors of the Florida State Board of Health.

Mr. Marion T. Jeffries, State Representative of the National Foundation, who planned the meeting in cooperation with members of the State Board of Health and who presided.

Representatives of the Office of Vocational Rehabilitation:

Mr. H. B. Cummings, Regional Representative (Region III).

Mr. Claud M. Andrews, Florida Director.

Mr. Glenn Calmes, Local District Representative.

Dr. W. W. Rogers, President of the Florida Public Health Association.

Mr. W. E. Arnold, immediate past president of the Florida Hospital Association.

Dr. L. J. Graves, Acting Director of Services for the Florida Crippled Children's Commission.

The second day's meetings, which took place at the Mayflower Hotel, were held primarily for representatives of the Florida County Chapters of the National Foundation.

Below is a brief resume of certain phases of these discussions:

### THE THREE MAJOR "BOTTLENECKS" IN POLIO CONTROL

**FIRST:** There are not enough hospital beds for polio patients. Infantile paralysis patients should be hospitalized very early, as early as possible. The average hospitalization period is from six to eight weeks, in some cases as long as twelve to eighteen months. The bed shortage exists for both acute and convalescent cases.



Keynoted on the program for the Florida Meeting on Infantile Paralysis were some really big names. Here is Dr. John L. Lavan, Director of Research for the National Foundation, who was visiting conference leader; Mr. Marion T. Jeffries, Florida Representative of the NFIP; and Dr. E. F. Hoffman, Director of Epidemiology for the State Board of Health. *(Staff photo)*

Plans should be made in each county and community by medical and hospital authorities, public health departments and local chapters of the National Foundation for the hospitalization of all polio cases. Recommendations call for having at least 22 hospital beds available for polio cases for every 100,000 population in time of epidemic.

County chapters can pay all or part of hospitalization costs, medical and surgical fees, if needed, for all medically indigent victims of infantile paralysis regardless of the date of onset of the disease. No case should go without proper treatment because of lack of funds.

County chapters, backed by the National Foundation, can pay for providing local hospitals with any equipment necessary for the care of polio cases. This does not include funds for building construction, of course, but the equipment furnished can be used for any purposes the hospital desires provided polio cases are given priority when they occur.

Both the planning for hospital beds and the equipping of hospitals should be in process now rather than awaiting the turmoil of a possible outbreak. Added funds for these purposes can be secured from the National Foundation if local funds are not adequate.



The gathering in Jacksonville for discussing problems of polio with Dr. John L. Lavan of the National Foundation for Infantile Paralysis brought a number of hard-working persons from the southern end of the State. They came representing their County Chapters of the Foundation. Reading left to right, here they are: Mrs. Edwin Lewis of Sebring, Mrs. R. R. Brown of Palm Beach, the Reverend A. Waldo Farabee of Naples, Miss Vernon Hill of Miami, Dr. J. R. Boulware of Lakeland, Miss Ella Jo Stollberg of Hollywood, Mrs. A. B. Monticino, physical therapist from Dade County, and Dr. F. W. Glenn of Miami. (Staff photo)

**SECOND:** There is an acute shortage of trained personnel, particularly of physical therapists, graduate nurses and physicians with special training in orthopedic care. The National Foundation is trying to help to overcome this shortage through offering grants for scholarships in physical therapy and health education, for additional training to graduate nurses in orthopedic care, to physicians in latest methods of treatment.

During an epidemic, local shortages of trained personnel can be eased somewhat when, on the call of the State Health Officer, the Foundation will send units of trained workers wherever they are needed, insofar as possible. Each unit consists of an orthopedic surgeon, a pediatrician, a physical the-



rapist and a nurse. These units do not take over the directive phases of any establishment but are directly sent to assist in any way they can. They can demonstrate what can be done in the way of treatment in hospitals. They will give additional training to nurses in specialized techniques.



Also attending the State meeting was this delegation of County Chapter representatives: in front, Miss Jean Ivery, Secretary for the State office of the National Foundation in Orlando, Mrs. William Jayne, Orange County Representative, and Mrs. Paul K. Weaver of Osceola. In back: Dr. William F. Davey of Daytona Beach, Ralph A. Marsicano of Tampa and R. Earl Kipp of Sanford. (Staff photo)

Despite these efforts, however, the supply of trained personnel will be necessarily slow in reaching the needed numbers. These vocational opportunities should be pointed out to as many persons as are personally qualified to enter these fields.

**THIRD: There is an insufficiency of diagnostic facilities.** When an epidemic occurs, county chapters can supply funds needed for securing diagnoses. The chapter can pay for as many medical consultations as are necessary whenever individuals are unable to carry all, part, or any of the costs. The chapter can pay for transporting cases in rural areas to the nearest diagnostic center.

(Continued on Page 118)

## NOTICE---A RECENT RELEASE

U. S. Department of Labor  
Children's Bureau  
Washington 25, D. C.

### MEMORANDUM

Executive officers of State crippled children's agencies

From: Dr. A. L. Van Horn, Director, Division of Health Services

Subject: Admission of children with poliomyelitis to general hospitals.

In connection with the question as to whether it is safe to admit patients with poliomyelitis to the general wards of hospitals, you will be interested in an exchange of letters published in the May 19, 1945 issue of the **National Foundation News**.

March 16, 1945

**"Dr. Ernest L. Stebbins, Commissioner  
New York City Department of Health, N. Y. C.**

**Dear Dr. Stebbins:**

The National Foundation for Infantile Paralysis has been very interested, of course, in the statement issued last June by the Advisory Group on Poliomyelitis to the New York State Department of Health and the New York Department of Health that Infantile Paralysis patients may be safely admitted to the general wards of hospitals during the acute stages of the disease.

I am writing to inquire of the experience of the New York City Health Department in respect to this recommendation. Did it work out satisfactorily during the 1944 outbreak?

It would seem that this is a very sound attitude to take toward the disease, and that the practice should be extended. Yet I hesitate to request Chapters of the National Foundation to advocate the general adoption of this practice without learning of your experience.

Yours very truly,

Signed: Don W. Gudakunst, M. D.  
Medical Director"

"Dear Dr. Gudakunst:

April 3, 1945

This is in reply to your inquiry of March 16, 1945 regarding our experience with infantile paralysis patients on general wards of hospitals during the acute stages of the disease.

During the 1944 epidemic, 1,558 patients were treated in hospitals in the city. Of these, 1,170 were treated in either Willard Parker Hospital, Kingston Avenue Hospital, or Queensborough Hospital, the three communicable disease hospitals of the city. The remainder, 388, were treated in general hospitals. Some of them may have been treated in private rooms, but it is believed that the majority were treated in wards. No secondary case of poliomyelitis as a result of exposure to a case treated in the wards of a general hospital came to our attention.

Sincerely yours,

Signed: Frank A. Calderson, M. D.  
Deputy and Acting Commissioner"

The statement of the Advisory Group on Poliomyelitis of the New York City Health Department that pertains to this subject recommends that:

"All patients in whom a diagnosis of anterior poliomyelitis is suspected should be cared for in a hospital and that these patients may be safely admitted to the general wards, but that it might be desirable to separate the patients in special wards for ease in handling."

## SCHOLARSHIPS IN PHYSICAL THERAPY

Over a million dollars has been appropriated by the National Foundation for Infantile Paralysis for Scholarships open to young men and women who have been graduated from accredited schools of nursing or physical education, or who have completed a minimum of two years of college work with emphasis on biology and other basic sciences.

Scholarship recipients will be trained at approved schools for the treatment of all types of illness and disability in which physical therapy is used, be equipped to serve under the supervision of doctors in various kinds of practice and will not have to restrict their activities to the treatment of polio patients alone.

A pool of greatly needed professional workers will be made available, however, and persons so trained may be called in time of outbreak or epidemic. Write to the National Foundation (120 Broadway, New York) or ask your county chapter for further details.

## NOTES ON FLORIDA MEETING (Continued from Page 115)

The added medical training necessary for making accurate diagnoses cannot be secured overnight, however, nor can other personnel needed in time of outbreak. These needs must be foreseen and planning done in advance for securing diagnostic facilities so that the funds available for paying for these services can be applied when needed.

The diagnoses and reporting of infantile paralysis is much improved in recent years. However, although 19,280 cases were reported in the United States in 1944, it is estimated that about 30,000 cases probably occurred that year.

Cases should be reported by the day of the onset of the disease insofar as possible. It is more important to know the exact day the case came down with polio than the date it was reported to the health department.

Medical care of indigent polio cases will be financed by the National Foundation through the county chapters. For transients whose residence cannot be clearly established in any county, the Foundation will take care of any case of poliomyelitis directly, if needed.

One half of the money raised through the annual "March of Dimes" campaign remains in the county in which it was contributed. The other half goes to the National Foundation for Infantile Paralysis and is used, through their grants, for:

- ★ Research into the nature and effects of the virus that causes the disease.
- ★ Research on the prevention of polio and on the treatment of after effects.
- ★ Research related to the spread of the disease, epidemics and public health.
- ★ Granting of funds for scholarships for training physical therapists, health educators, and offering added training for graduate nurses and physicians.
- ★ Providing epidemic aid in the field including the services of trained nurses, physical therapists, physicians, and other expenses connected with supplying respirators and other needed equipment.
- ★ Backing up the local chapters with either money or services as needed. County chapters needing additional funds for direct aid to victims within their territory can secure these so that no local needs for funds are unmet.

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**THERE IS NO KNOWN CURE FOR INFANTILE PARALYSIS. GOOD MEDICAL CARE WILL PREVENT OR CORRECT SOME DEFORMITIES. DO NOT BELIEVE THOSE WHO PROMISE TO CURE ALL CASES. BE GUIDED BY SOUND MEDICAL ADVICE.**

# **NUMBER OF CASES OF POLIOMYELITIS REPORTED IN FLORIDA BY COUNTIES**

*(From the records of the Bureau of Epidemiology, Florida State Board of Health)*

County	Cases reported during 1944	Total Number of cases reported for last ten-year period (1935 through 1944)	Cases reported dur- ing 1945 through week ending July 21st
Alachua	1	22	0
Baker	0	1	0
Bay	0	11	0
Bradford	0	1	0
Brevard	0	3	0
Broward	0	14	0
Charlotte	0	1	0
Citrus	0	5	0
Clay	1	4	2
Columbia	0	9	0
Dade	35	123	4
DeSoto	0	1	0
Dixie	0	1	0
Duval	9	96	2
Escambia	9	65	1
Flagler	2	2	0
Gadsden	0	7	1
Glades	1	2	0
Gulf	0	5	0
Hendry	1	1	0
Highlands	3	9	2
Hillsborough	10	48	2
Holmes	0	5	1
Indian River	0	13	0
Jackson	0	9	0
Jefferson	0	3	0
Lafayette	0	1	0
Lake	1	11	1
Lee	0	2	1
Leon	1	16	0
Levy	0	2	0
Liberty	0	2	0
Manatee	4	6	1
Marion	7	12	0
Martin	0	2	0
Monroe	2	10	0
Nassau	0	5	0
Okaloosa	2	3	0
Orange	5	21	0
Osceola	0	1	0
Palm Beach	3	14	10
Pasco	0	2	0
Pinellas	5	23	1
Polk	4	22	1
Putnam	0	3	0
St. Johns	0	4	0
St. Lucie	0	3	0
Santa Rosa	0	2	0
Sarasota	0	2	0
Seminole	0	1	1
Sumter	0	5	0
Suwannee	0	4	0
Taylor	1	4	0
Union	0	2	0
Volusia	0	10	0
Wakulla	0	1	0
Walton	0	2	0
Washington	0	1	0

*(The nine counties not listed reported no cases during the periods named)*



## KEY PERSONS TO CONTACT FOR INFORMATION AND ASSISTANCE IN CASES OF ACUTE POLIOMYELITIS

COUNTY	County Health Officers or Local Assistant Collaborating Epidemiologists	Supervisors of Public Health Nursing or Key County Nurses	Chairmen of Florida County Chapters of the National Foundation for Infantile Paralysis
Alachua	F. M. Hall, M.D. County Health Dept. Gainesville	Miss Louise Kincaid, Supervisor County Health Dept.	Mrs. S. M. Kennedy High Springs
Baker	John W. McClane, M.D. County Health Dept. Maccleenny	Miss Bertha Todd	Mr. W. B. Cone Maccleenny
Bay	J. O. Barfield, M.D. County Health Dept. Panama City	Miss Betty Ficquett, Supervisor	Mrs. Carolee Lahan Laguna Beach Panama City
Bradford	Irving R. Abrams, M.D. County Health Dept. Starke	Mrs. E. J. Haroutunian	Mr. N. Sternberg Starke
Brevard	G. E. Christee, M.D. County Public Health Clinic Titusville	Mrs. Geraldine DeLoe Country Club Colony Melbourne Mrs. A. Bossidy Box 302, Cocoa	Mr. Stuart Clark Cocoa
Broward (North)	W. C. Hatchett, M.D. County Health Dept. Ft. Lauderdale	Mrs. N. M. Kessler, Supervisor County Health Dept.	Mrs. Opal Smith 121 N.E. 9th Ave. Ft. Lauderdale
Broward (South)	W. C. Hatchett, M.D. County Health Dept. Ft. Lauderdale		Miss E. J. Stollberg 204 Morse Arcade Hollywood
Calhoun	M. Q. Burns, M.D. County Public Health Clinic Blountstown		Mr. J. D. Hall Blountstown
Charlotte	M. J. Alexander M.D. County Public Health Clinic Punta Gorda	Mrs. Clennie Hickok	Mr. W. B. Clemm Punta Gorda
Citrus	C. L. Carter, M.D. County Public Health Clinic Inverness	Mrs. G. W. Bowles	Dr. W. B. Moon Crystal River
Clay	Irving R. Abrams, M.D. County Health Dept. Green Cove Springs	Mrs. C. Canova	Mrs. J. W. Clerke Green Cove Springs
Collier	F. J. McKinley, M.D. City Public Health Clinic Everglades		Rev. A. W. Farabee Naples
Columbia	Joseph P. Burns, M.D. County Public Health Clinic Lake City	Mrs. M. B. Ramsey	Mr. James B. Hodges Lake City
Dade	T. E. Cato, M.D. County Health Dept. Miami	Mrs. M. B. Matthews, Supervisor County Health Dept.	Mr. A. J. Cleary 148 W. Flagler St. Miami
DeSoto	C. H. Kirkpatrick, M.D. County Public Health Clinic Arcadia	Miss Florence Ferry	Mr. John Woodley Arcadia

COUNTY	County Health Officers or Local Assistant Collaborating Epidemiologists	Supervisors of Public Health Nursing or Key County Nurses	Chairmen of Florida County Chapters of the National Foundation for Infantile Paralysis
Dixie	J. M. Anderson, M.D. County Public Health Clinic Cross City	Miss Margaret Avant	Mr. T. P. Chaires Old Town
Duval	Geo. A. Dame, M. D., Director Local Health Service State Board of Health Jacksonville	Mrs. I. M. Nelson Supervisor County Health Dept.	Mr. Horace Long 60 Stockton St. Jacksonville
Escambia	T. W. Reed, M.D. County Health Dept. Pensacola	Miss Erma Williams, Supervisor County Health Dept.	Mr. J. A. Alvarez State Oil Company Pensacola
Flagler	Joseph M. Rose, M.D. County Public Health Clinic Bunnell		Mr. T. E. Holden Bunnell
Franklin	A. E. Conter, M.D. County Health Dept. Apalachicola	Mrs. R. H. Beardslee	Mr. J. G. Bruce Apalachicola
Gadsden	Geo. A. Dame, M.D. Director Local Health Service Fla. St. Bd. of Health Jacksonville 1	Mrs. A. Hancock, Supervisor County Health Dept.	Mr. T. R. Smith Quincy
Gilchrist	E. F. Hoffman, M.D. Director, Epidemiology State Board of Health Jacksonville 1		N. R. Lancaster Trenton
Glades	James C. Wells, M.D. County Health Dept. Court House Moore Haven	Mrs. Mary L. Ryon	Mrs. L. Gorman Lakeport
Gulf	T. A. Meriwether, M.D. County Health Dept. Port St. Joe	Mrs. L. S. Ellsworth	Mr. E. C. Lewis, Jr. Port St. Joe
Hamilton	Sybill Corbett, M.D. County Public Health Clinic Jasper		Mr. J. Graham Black Jasper
Hardee	M. C. Kayton, M.D. County Public Health Clinic Wauchula	Mrs. Lucy Barlow	Dr. B. D. Spears Wauchula
Hendry	Cleo E. Weaver, M.D. County Public Health Clinic La Bohle		Mr. U. T. Koch Clewiston
Hernando	G. R. Creekmore, M.D. County Public Health Clinic Brooksville	Mrs. A. M. Downs	Prof. J. C. Lane Brooksville
Highlands	Jas. C. Wells, M.D. County Health Dept. Sebring	Mrs. M. D. Bennett	Mrs. Alice Lewis (Vice-Chairman) Sebring
Hillsborough	F. V. Chappell, M.D. County Health Dept. Tampa	Mrs. J. M. Moore, Supervisor County Health Dept.	Mr. W. E. Thompson 914 First Nat. Bank Tampa

COUNTY	County Health Officers or Local Assistant Collaborating Epidemiologists	Supervisors of Public Health Nursing or Key County Nurses	Chairmen of Florida County Chapters of the National Foundation for Infantile Paralysis
Holmes	L. H. Paul, M.D. County Health Dept. Bonifay	Miss L. R. Buckley	Mr. L. D. Padgett Bonifay
Indian River	P. T. McClellan, M.D. Public Health Clinic Vero Beach	Mrs. Alice Helleso	Mr. E. W. Jacocks Vero Beach
Jackson	C. A. Adams, Jr., M.D. County Health Dept. Marianna	Miss Alma Wandeck	Mrs. A. J. Lewis Marianna
Jefferson	F. A. Brink, M.D. County Health Dept. Monticello	Miss Sylvia Erb	Mr. R. H. Simpson Monticello
Lafayette	O. F. Green, M.D. Public Health Clinic Mayo		Mr. S. A. Wilson Mayo
Lake	R. J. Dalton, M.D. County Health Dept. Tavares	Miss Cecilia O'Berry Supervisor County Health Dept.	Mr. Lacy G. Thomas Groveland
Lee	Baker Whisnant, M.D. Public Health Clinic Fort Myers	Mrs. Lucy Nelson	Ernest J. Cassen Hotel Royal Palm Fort Myers
Leon	P. J. Coughlin, M.D. County Health Dept. Tallahassee	Miss M. Murphy, Supervisor County Health Dept.	Mr. M. E. Tolson Secy. of State Office Capitol Bldg. Tallahassee
Levy	S. L. Turner, M.D. County Health Dept. Bronson	Miss Agatha Howell	Mr. Jack L. Meeks Bronson
Liberty	M. Q. Burns, M.D. Public Health Clinic Bristol		Mr. S. I. Revell Bristol
Madison	C. A. O'Quinn, M.D. County Health Dept. Madison	Mrs. Bertha I. Pinson	Mr. E. B. Brownng Madison
Manatee	S. G. Hollingsworth, M.D. County Health Dept. Bradenton	Miss Irene Fitzgerald	Mr. W. J. Ray Bradenton
Marion	E. G. Lindner, M.D. County Health Dept. Ocala	Mrs. Cora Bay	Mr. Ernest Nott Box 545, Court House Ocala
Martin	J. D. Parker, M.D. Public Health Clinic Stuart		Mrs. Ted Chambers Stuart
Monroe	D. A. Baldrige, M.D. County Health Dept. Key West	Mrs. B. M. Preston	Mr. Ralph Sierra Box 224 Key West
Nassau	J. W. McClane, M.D. County Health Dept. Fernandina	Mrs. G. D. Batchford	Mr. A. H. Stier Fernandina
Okaloosa	Rhett E. Enzer, M.D. County Health Dept. Crestview	Mrs. R. H. Demmith	Mrs. L. M. Jackson Fort Walton
Okeechobee	E. F. Dudley, M.D. Public Health Clinic Okeechobee	Miss Hallie Davis	Mr. R. B. Meserve Okeechobee
Orange	W. P. Rice, M. D. County Health Dept. Orlando	Mrs. Olivia J. Todd, Supervisor County Health Dept.	Mr. Haldane Huckel 213 N. Main St. Orlando

COUNTY	County Health Officers or Local Assistant Collaborating Epidemiologists	Supervisors of Public Health Nursing or Key County Nurses	Chairmen of Florida County Chapters of the National Foundation for Infantile Paralysis
Osceola	George Gartley, M.D. Public Health Clinic Kissimmee		Mr. Sam L. Lupfer Kissimmee
Palm Beach	W. E. VanLandingham City Health Dept. West Palm Beach	Miss J. T. McDaniel	Mrs. R. R. Brown 2935 Washington Rd. West Palm Beach
Pasco	W. W. Jones M.D. Public Health Clinic Dade City	Mrs. Anne T. Kelley	Mr. B. F. Parsons Zephyrhills
Pinellas	R. D. Hollowell, M.D. Public Health Clinic St. Petersburg	Mrs. Martha Stetson, Supervisor County Health Dept.	Dr. P. LeBreton 613 9th Ave. South St. Petersburg
Polk	L. M. Zell, M.D. County Health Dept. Bartow	Mrs. Margaret Mills	Dr. L. R. Boulware Lakeland
Putnam	C. M. Knight, M.D. Public Health Clinic Palatka	Mrs. Nina H. Moore	Mr. T. B. Dowda 413 Lemon St. Palatka
St. Johns	Herbert White, M.D. City Health Dept. St. Augustine	Miss Edith M. Talpey	Mr. X. L. Pellicer (Treasurer) Davis Shores
St. Lucie	L. A. Whiddon, M.D. Public Health Clinic Ft. Pierce	Mrs. L. H. Wiggins	Mrs. E. D. Cahow Box 568 Ft. Pierce
Santa Rosa	T. W. Reed, M.D. County Health Dept. Milton	Mrs. G. O. Teusink	Dr. J. C. Holley Milton
Sarasota	F. L. Hall, M.D. Public Health Clinic Sarasota	Mrs. Ruth Wilhelm	Mr. L. D. Reagin Sarasota
Seminole	L. H. Dame, M. D. County Health Dept. Sanford	Mrs. Huda Kibbee	Dr. L. T. Doss Atlantic Bdg. Sanford
Sumter	R. J. Dalton, M.D. County Health Dept. Bushnell		Mrs. D. L. Belton Sumterville
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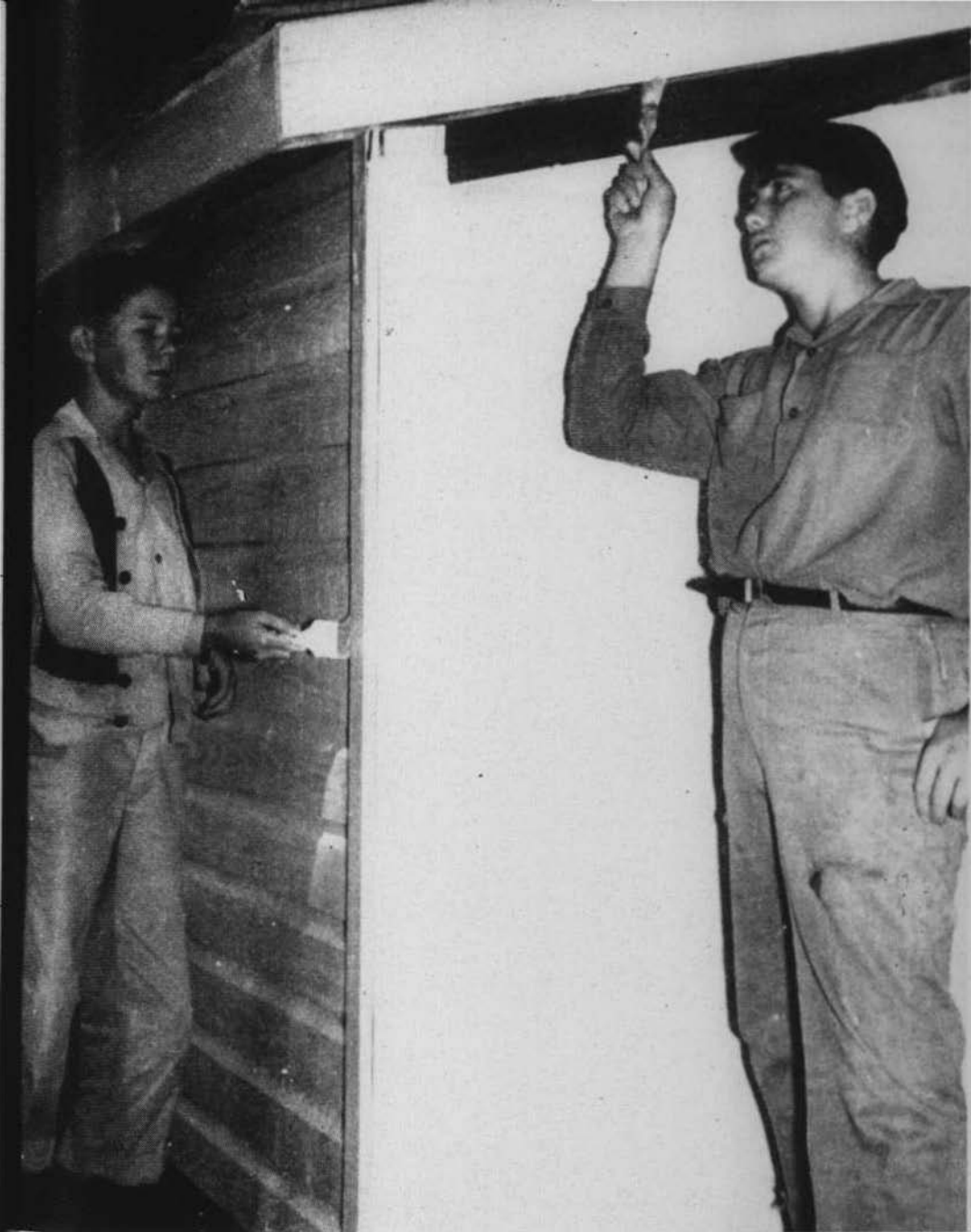
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For further information concerning the Florida State Office  
of the National Foundation for Infantile Paralysis write:

Mr. Marion T. Jeffries  
State Representative, NFIP,  
512 Florida Bank Building  
Orlando, Florida

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# *Florida* **HEALTH NOTES**

PUBLISHED BY THE FLORIDA STATE BOARD OF HEALTH

JACKSONVILLE • SEPTEMBER, 1945 • VOL. 37 • No. 9

**SCHOOL HEALTH**

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# Florida HEALTH NOTES

ESTABLISHED 1890

## SCHOOL HEALTH

Last year we held high our editorial "loving cup," if you recall, to the schools . . . to students, teachers, health department personnel or others connected with the many fine school health programs we knew were in progress. An award of publication in this year's School Health Number of HEALTH NOTES was promised to those submitting the best reports of sound projects.

We wish you could see the splendid reports we have received! This issue is full to overflowing because there were so many valuable activities reported that some of them just couldn't be left out!

The prize winners? Three of them are reported herein. There were many prize winners, really. But these three combined their splendid work with equally splendid reports. Basically, however, they are prize winners because their programs are sound, destined to expand with far reaching results. Why?

Because these school health programs are based on the fundamental principle that "health education is a way of living, as well as a subject to be taught." These programs are based on "doing" rather than on "talking about it." They are consistent with the principles of general education practiced in these same schools, principles recommended by the Florida State Department of Education as well as those concerned with public health education.

These programs are based on the real public health problems of the people. They are based on Florida health problems, particularly in respect to the areas concerned. Above all, they are co-operative projects, planned and put into action by intelligent educators who are not satisfied to tackle health problems merely from within the four walls of the little red school house, nor merely from within the covers of a textbook.

Those who undertook these projects knew that progress toward solving health problems can only be made when health education extends in a planned, definite and coordinated way into the personal and family living of the pupils, parents, teachers, neighbors and as far as possible into total community life.

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## "HOOKWORM vs. HEALTH"

*Excerpts From a Report Written by the Eighth Grade,  
Glen St. Mary School, Glen St. Mary, Baker County, Florida*

Because of our study, "Hookworm vs. Health," we feel that we are more a part of the County in which we live and although we are just eighth graders there are responsibilities for us to shoulder.

WE THEREFORE RESOLVE that we will cooperate with the County Health Department and all other agencies and persons interested in ridding Baker County of this dangerous parasite Hookworm, thus placing this County on a higher education and health level. We also hope that this program in Baker County will prove to be such an inspiration to all sister counties that they will determine to change the heavily infested map of Florida from black to white.

(Signed) The Eighth Grade, Glen St. Mary.

Our public health nurse, Miss Bertha Todd, visits us often. One day last spring she told us our hookworm tests showed that many of us had hookworms. Many had not turned in bottles, too, she said. (39.3%, we figured out later in arithmetic.) Miss Todd was giving out treatments under our health officer's, Dr. McClane's directions. Some of the children were not even taking the medicine when they knew they had hookworm—even some in our class, the eighth grade,—top class at school!

About the same time, Miss L. E. Jones, of the School Service Bureau of the University of Florida, was making plans with Mr. Burnsed, our County Superintendent, and with Mrs. Irene Christen, our County Supervisor. Mr. Burnsed wanted to carry on a project in one of the schools. He always likes to get right into our schools and to know the boys and girls and teachers well. Miss Jones and Mrs. Christen, who felt that hookworms were probably holding back many of the children, suggested that he work on a hookworm teaching project.

Mr. Burnsed came out to talk to our teacher, Mrs. Foley, just after Miss Todd, our nurse, had been here and . . . that is how our class study, "Hookworm vs. Health" got started.

To find out more about hookworm disease we did many things. Miss Todd helped us a great deal. She brought pamphlets from the health department and asked if we would like to have Dr. Harris, our county sanitary officer, come out to show us some of his "pet hookworms" that he keeps in a jar.



Ring leaders of Glen St. Mary's school health project put their plans together and keep them together Left to right: Mrs. H. T. Foley, eighth grade teacher, Mr. J. D. Burnsed, Baker County Superintendent of schools, and Miss Bertha Todd, Public Health Nurse with the County Health Department.



He came, too! And he **did** show us those hookworms hooked onto the intestines of a dog! He also showed us a little privy and told us why the right kind of toilets were necessary in stopping hookworms.

Mrs. Foley and Mr. Burnsed helped, too. They are the kind of teachers who know how to capture our interest and hold it! They knew how to get us to doing a little bit of hookworms with geography, some hookworms with history, with science, reading, spelling, word study, writing and speaking.

Right away we were writing letters. Sixty-five letters, we wrote in all, inviting visitors from the health unit, the State Board of Health and the University to talk to us and give us information and advice. We learned to write these letters in business form and in good English. The pupils with the neatest penmanship got to copy the final letters sent to the persons we invited.\* Later we even typed sample telegrams, connected with our study of communication, inviting out of school guests to our final big program for parents. We mailed these for three cents, though.

By the way, one of our "history hookworm questions" has never yet been answered. Does anyone know who discovered, or first saw ("identified," as Miss Todd puts it), the first hookworm?

Surveys were made in all rooms to find out how much of a problem hookworms were in our school. This was done by committees, explained later. From the statistics they gathered we made up and solved arithmetic problems on the percentages of pupils tested, treated, having or needing sanitary privies, on the costs of lumber, labor and materials for privies.

We studied facts about hookworm from the pamphlets Miss Todd gave us, from FLORIDA HEALTH NOTES, from the World Book Volume No. 5 (1931), the 1932 Yearbook of Agriculture (page 764) and from the Lincoln Library of Essential Information.

An interesting story called "Pineville High Meets the Challenge" was loaned to us by Miss Jones. It describes how a school football team decided to be a "hookworm team" until they ridded themselves and finally their whole school of the disease. Miss Jones wanted our opinion of the

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\*We thank the following persons very much for coming and helping us: Dr. S. F. Harris, Miss Bertha Todd and Mrs. Annie Elliott of the Baker County Health Department; Miss L. E. Jones and Mrs. Lillian Hough, College of Education, University of Florida, Gainesville; Mrs. Elsie D. Withey, Dr. Lucille Marsh, Miss Marjorie Morrison and Miss Ruth Allen from the State Board of Health, Jacksonville.

## A PAGE FROM OUR SCHOOL NEWSPAPER

GLEN SPECIAL NEWS  
April 16 Volume No. 12

## JOKES

Frankie: "Fay, do you know little Hookie?"

Fay: "Little Hookie Who?"

Frankie: "Little Hookie Hookworm!"

## LITTLE HOOKIE HOOKWORM

Little Hookie Hookworm hatched out in the sandy soil and moist climate in Glen St. Mary, Florida. After hatching out and lying on the surface sunning himself he was wishing for someone to come along so that he might get to work and find him a home.

It was spring, the time of year when children like to go barefooted and Melven was no exception. Shedding his shoes, he takes a race around the house and right through the polluted soil he goes where Little Hookie is waiting for him.

In a few days we find Melvin sitting on the steps scratching his feet with a

vim and we hear Little Hookie as he says, "Aha, I am inside now and you can't get me out! I got on your feet as you ran through the grass and now I am where no harm can come to me."

(continued, page 4)

Dr. S. F. Harris, our country sanitary officer, accepted our invitation and visited us Friday.

He brought with him a bottle with hookworms attached to the small intestine of a dog. He also brought with him a miniature sanitary privy. This, he said, meant Death to the Hookworm.

We enjoyed his talk very much and hope soon to construct one of those privies. After learning how we already have orders for building three more.

In our recent survey of the school on sanitary privies we received forty-eight requests for Dr. Harris to visit parents' homes and talk with them concerning the cost and construction of one on their place.

The Glen St. Mary school newspaper was full of "hookworm news" . . .

## LETTERS WE RECEIVED

## FROM OUR PUBLIC HEALTH NURSE:

"I feel that the work done by the 6th grade at Glen St. Mary School has been very beneficial. They increased the interest of the students. They were able to do this by visiting the rooms and talking with each student.

"This grade took the responsibility of seeing that this school was free from Hookworm. In their approach to the students they were able to accomplish more than some one just coming in from time to time.

"I feel that this program has been a learning experience for students and parents. I have never seen a program like this before. It is the best piece of work I have ever seen along this line. It was not only beneficial to the children, but also to the parents as well and in turn to the community.

Bertha Lee Todd, Public Health Nurse  
Baker County Health Department  
Macclenny, Florida

## FROM ONE OF MANY PARENTS:

"I have read your news items each week in your school paper and never knew before how dangerous the hookworm is. That was one of the most educational programs I have ever seen.

A Parent, Glen St. Mary, Florida

## FROM ANOTHER TEACHER:

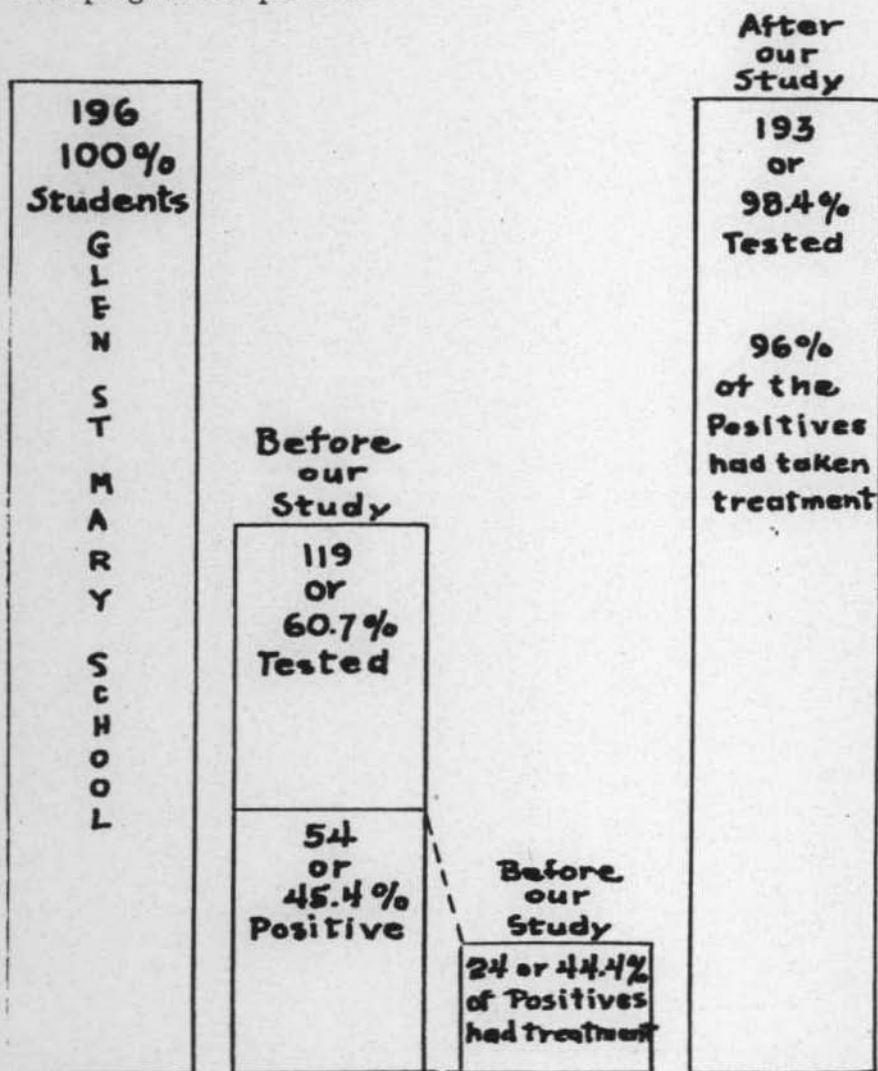
"I had used all my efforts to make our room 100% tested and treated but four pupils stood out to the end until the eighth grade took over the work. They were instrumental in getting all but one to take test and treatment. This one had taken the treatment the year before and seemed in fine physical condition. It was a splendid piece of work.

Mrs. Branch Cone,  
6th Grade Teacher  
Glen St. Mary School

When you write letters, they say, you receive them! Sixty-five letters written by Glen St. Mary's eighth graders brought their rewards!

story because it is to be printed so all the boys and girls can read it. We are glad this will be done because the story gives many ideas for school projects to get rid of hookworms.

We listed and studied twenty new words, outlined our study, drew maps of Florida and Baker County showing hookworm infestation, made charts for talks on hookworm in the other rooms and wrote many verses and parts for our final program for parents.



This composite of several graphs made by students at Glen St. Mary shows what boys and girls can do when they get back of a health program.

Several weeks were spent gathering facts. We learned a great deal about the hookworm and its life cycle, about how hookworm disease infests us (one of our new words: "infests," as different from infects") and how the disease can harm us. We also learned why sanitary toilets are so important. Knowing more about our problem, we determined to do something about it. We resolved to do all that we, the eighth grade, could do to:

1. **Rid our school of hookworms, by:**
  - a. **Getting 100% of the pupils tested, if possible.**
  - b. **Getting 100% of those with hookworms to take treatments.**
2. **Helping our community to get rid of hookworms by:**
  - a. **Seeing that sanitary privies are built where needed and where possible.**
  - b. **Asking parents to get younger children and themselves tested and treated at the health department.**

This is a list of some of the many things we did trying to accomplish our aims:

- ★ **Chose a committee of girls to visit each room** to get information and to appoint and help room captains to lead the drive in each room. The girls went to each room every week for eight weeks, giving talks and trying to get all students tested and treated if needed. We surely appreciate the way Miss Todd backed up this committee, too.
- ★ **Chose a committee of boys to visit each room** to check on what the children knew of their home sanitary conditions. Room captains among the boys were chosen to help all needing sanitary privies to start getting them. Dr. Harris deserves thanks for his help here. **Wrote letters to our parents** and asked the other upper grades to write to theirs about our study and about helping with the testing, treatment and privy programs.
- ★ **Took notes and wrote up stories or reports** on what was said by each speaker who visited us. The best write-ups were put in our school newspaper so that other students and our parents could learn what we had learned.
- ★ **Built a sanitary privy on the school grounds** under Dr. Harris' supervision. This privy is to be used in one of the Negro schools. The County School Board paid for the materials. The boys who worked hardest on it, Orie Hicks and Albert Byrd, are going to help Dr. Harris this summer with building some of the privies for which we got orders.
- ★ **Played a game called "Vitamingo"** that Miss Morrison of the State Board of Health showed us when she told us about the foods we need every day and about those we need especially if we have had hookworm disease. We played this game every day for a long while, talked about foods at home and planned family menus.



Dr. S. F. Harris, Baker County Sanitary Officer, guides the endeavors of eighth grade Orie Hicks and Albert Byrd in privy building. Supplies were purchased by the County School Board. After its display under the spotlight on Glen St. Mary's school grounds the night of the program for parents, the privy was installed for use at one of Baker County's Negro schools. —(Staff photo).



**★ Worked very hard on our final program for parents.** We drew posters and wrote letters about it, helped each room to plan their part in the program and wrote asking for films from the Bureau of Health Education at the State Board of Health. Every grade in the school and almost every child had a part. Room captains gave reports of the final number tested and treated. About 150 parents came to our program and many out of town visitors as well as faithful Miss Todd, Mrs. Elliot and Dr. Harris from the health department. Every teacher in the school, as well as our principal, Mrs. Sally O'Hara, worked very hard to help us.

We thank one and all who helped us with our study. And we thank the many who wrote us such interesting letters about our project. Did we accomplish our aims? Not quite 100%, but we believe we did well for the eight weeks we worked on it. Although our charts tell the story, we did this much:

**60.7% (119) of our 196 pupils had been tested before we began.**

**98.4% (193) had been tested at the close of school.**

**44.4% (24) of those having hookworms (There were 54 positives out of 119 tests) had taken treatment when we began**

**55.6% (30) of the positives had not taken treatment**

**96.0% of those whose reports had come back positive had taken treatment at the close of school (not quite all reports had come back).**

**92 families do not have sanitary privies.**

**3 direct orders for privies were made.**

**46 requests came for Dr. Harris to see parents about constructing privies as a result of our drive.**

The job is not finished yet. A committee of two seventh grade girls and two seventh grade boys, however, has been appointed to carry on this work for the coming school year. We wish them all success and hope they learn and benefit as much as we did from the study.

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Orie Hicks and Albert Byrd (front cover) prove they meant business when they said "down with the hookworms!" Co-chairmen of Glen St. Mary's eighth grade Privy Committee, they are shown learning how to build a privy right there on the school grounds . . . are spending the summer building them to help fill orders the committee received during their school study. (See page 133).



## EMERGING: A COOPERATIVE HEALTH PROGRAM AT EAST MARION

*Compiled From a Report Written by  
Mrs. Dorothy Waters, Senior English Teacher  
East Marion School, Lynne, Marion County, Florida*

### FOREWORD

We teachers were faced with a "proposition" at a faculty meeting in early January this last school year. It had something to do with health program. We knew that Mr. Joe E. Brown, our principal, was quite concerned about several health problems. He, particularly, and many of us remembered the nutrition examinations that had been given several years by Dr. Ouida Abbott of the Agricultural Extension Service of the University of Florida. The examinations had shown, among other things, that a considerable number of children had had at least borderline cases of nutritional anemia.

Attention had been paid to nutrition during the follow-up after the examinations, but we wondered about the present nutritional status of the children after this time lapse. We knew of several other problems. But we did not know about this "program" we were being called in to consider.

Here is what had happened. Mr. Brown had conferred with Mr. Landis Blitch, acting County Superintendent, and both of these men had talked with representatives of several State agencies concerning plans for our county school health program.

As a result, these underlying thoughts were presented at our faculty meeting:

★ That health education, needed for the eventual solving of practically all health problems, cannot be separated into school health education and adult health education because most health problems are not so "separated."

★ That community health education, rather, is an over-all endeavor that demands the close cooperation of all groups interested in health, including of course, the schools.

★ That many things can be done by each community group, but rarely can any one of these groups solve public health problems alone. Much more can be done, therefore, if there is mutual planning and joint action on the part of all concerned.

This is not a new idea, certainly, but getting it done was another story. We teachers certainly knew from experience how difficult it was to do much on children's health problems without home cooperation. We already knew how basic it was for us to work closely with the health department. But how reach the home? How could this "community cooperation" come about? What agencies or groups could do what? What health problems should be tackled first?

That, then, was the "proposition"! Could we, as a school faculty, exert the initiative in our small community in calling together the local groups interested in health problems? Could we find our major health problems and plan mutually for attacking them?

Could we follow through? Were we teachers willing to try? We knew we were, and voted to do our best, provided we were not expected to do the impossible—to solve all health problems at once—provided we could take on a little at a time, considering our relative chances for success as well as our greatest needs. How surprised we were later at the number of health problems in which we became interested!

**Mr. Brown's first move was to call together a preliminary group** of patrons, trustees, teachers and certain community representatives to meet with State consultants who had offered to assist. The purpose was to list our major health problems as we saw them and to make plans for a more permanent cooperative group—a local health council.

A representative of the faculty, of our Board of Trustees, of the PTA, of the students, the churches, the Missionary Society, of each of the three local home demonstration clubs, the County School Lunch Supervisor and a representative of the War Food Administration were present at this first meeting as well as the visiting consultants from the University, the State Board of Health and the Florida Tuberculosis and Health Association.

**Problems listed, merely from our observations, were those of hookworm, malaria, colds, defective teeth and eyes, faulty eating practices,** the local milk shortage, erroneous ideas about physical education, improper school lighting and others. It was felt that parents and representatives of county-wide agencies which serve our communities should be invited to attend future meetings of the council. This included, of course, the County Health Department (the Ocala-Marion County Health Department, supported wholly by local funds), the County Farm and Home Demonstration Agents, the County Tuberculosis and Health Association and others as needs arose.

**When the larger group of representatives met, including the county-wide agencies,** it was decided that each school grade should discuss its major health problems and present ways in which the home could assist with these problems. These were discussed with parents at the next PTA meeting and by letters home.

It was realized that although a number of health problem were recognizable among children, the records of the health examinations conducted by Dr. E. G. Lindner, City-County Health Officer, were to be studied closely.

For an over-all school project, therefore, the problems of nutrition claimed major interest. After further discussion, considering also the resources available and our comparative chances of success, **it was decided that nutrition, tuberculosis and hookworm be given major emphasis.**

It would be quite impossible to relate here all of the steps we went through, all of the many health activities that were parts of our project as it has evolved to date. Each grade had definite problems of its own that were worked on and that will continue to receive attention as long as necessary. Every grade, however, emphasized certain phases of nutrition, tuberculosis and hookworm.

It is also far too early to evaluate the degree to which health problems have been solved. No community is ridded completely of nutritional problems, tuberculosis and hookworm disease by one se-

mester of school emphasis, even with the splendid cooperation of community groups that we had. But much progress was made at East Marion. The nutrition survey disclosed that although deficiencies were not as numerous nor as severe, in general, as they had been several years ago, there were still many nutritional difficulties to be attacked. Records of dietaries showed definite improvements in eating practices at the end of the year, as did comparative observations made during school lunch periods. All students and many parents were x-rayed and learned the values of chest x-raying. The mobile x-ray unit of the Division of Tuberculosis Control, State Board of Health, was used in the survey.

**Outstanding was the degree to which home cooperation was achieved**, even with these early beginnings of our program. The turn-out of parents, wholly voluntary, of course, for both the nutrition survey and the x-ray examination was indeed encouraging, well over half of the parents being present for each of these procedures. Obviously the interest of other community groups was keen. The evidences of active cooperation on the part of all groups concerned—local, county and State—have already proven the values of this method of attack to us, although our project is young in respect to the results we expect to accomplish.

The real story . . . or at least parts of it . . . of our emerging program at East Marion can therefore best be told by the brief summary which follows, outlining the contributions of each of the major cooperating agencies in our program:

## **HIGHLIGHTS OF COOPERATIVE ACTION AT EAST MARION**

### **In Respect to:**

#### **The Nutrition Survey, the X-Ray Examinations, and Their Follow-Up Programs:**

(Sponsored by the East Marion Health Council with the active support of the East Marion School; its Parent-Teacher Association; the Moss Bluff, Conner and Lynne Home Demonstration Clubs; the Ocala-Marion County Health Department and Tuberculosis and Health Association. State health and educational agencies assisted.)

#### **The Ocala-Marion County Health Department:**

Approval and cooperation of this agency was secured before State Health Department services were requested. Dr. E. G. Lindner, Health Officer, assisted throughout. Mrs. Cora Bay, nurse for the health department, helped with the nutrition and chest x-ray examination. Health department records of hook-worm tests were submitted to Dr. Gates, the examining physician for the nutrition survey. The health department received reports of Dr. Gates' finding and of the x-ray examination in return.

**The State Board of Health:** Dr. Emily Gates, Assistant Director, and Miss Marjorie Morrison, Nutritionist, both of the Bureau of Maternal and Child Health at the State Board of Health, came at the request of the East Marion Health



Council to conduct the nutrition survey of school children and of all interested family members in the area. Children and adults were examined. These State workers also returned to demonstrate and explain the findings of the survey, and to point to needed action on the part of the school and parents. Miss Morrison returned several times to assist teachers with nutrition teaching units.

Mr. and Mrs. James Moorehouse came with the State Board of Health Mobile X-ray Unit at the request of the Health Council and the County Tuberculosis and Health Association to x-ray the school children, their parents and other adults.

Personnel of the Bureau of Health Education at the State Board of Health assisted with educational and publicity phases of the work. Pamphlet materials, informational booklets and films were provided, as were preliminary newspaper releases and news photos. The Ocala Star-Banner cooperated wholeheartedly throughout the program with state representatives and with Marjorie Peeples, the student publicity chairman and student representative on the Health Council.

**The Home Demonstration Clubs:** Miss Allie Lee Rush, County Home Demonstration Agent, and the three clubs in the East Marion area sent special notices and made successful efforts to get many families to come for the nutrition survey and the x-ray examinations and to the follow-up meetings. The Home Demonstration Clubs prepared displays of vitamin and mineral rich foods for the nutrition demonstration, at which time the findings of the examination were explained to parents and teachers by Dr. Gates. Posters and pamphlet material on foods were made available from the county office.

A nutrition class was organized by Miss Rush the night of the nutrition demonstration. Twenty-five parents and teachers completed the course.

Work was done by the East Marion 4-H Club in connection with their school nutrition study and with the regular 4-H Club nutrition program. This work was closely correlated with the nutrition survey and its findings.

**The East Marion P. T. A.:** Secured the cooperation of the churches and Missionary Society in announcing the surveys and inviting adults, sent special notices to all members urging them to participate in the nutrition testing and x-ray programs personally as well as in respect to their children, held a covered-dish supper for all community members preceding the nutrition demonstration at the school, and assisted in many other ways.



What's good for Jo and Sally is usually good for Mamma, Papa and Teacher, his turn for hemoglobin test, takes his turn for hemoglobin testing by Dr. Emily Gates of the State Board of Health. Mrs. Cora Bay, nurse with the Ocala-Marion County Health Department, assists, while Mrs. Joe E. Brown, patron, Mrs. Dorothy Waters, teacher, and Mrs. W. C. White, Moss Bluff Home Demonstration Club president, await their turns.

(Staff photo).

While Dr. Gates is finishing up with some of the adults, Marjorie Peebles, student representative on East Marion's Health Council, registers the next group of children for hemoglobin testing during the Nutrition Survey. (Staff photo).





See the Chief Big Cooperators! The "Who's Who" that planned together and worked together on the East Marion School Health project! How many can you identify? A few last-name-hints (see the article for their positions, etc.) are: Morrison, Nutter, Ensign, Bay, Blitch, Waters, Jones, Brown, Pynchon. The rest is up to you!

**The State and Local Tuberculosis and Health Associations:** Mrs. Grace Ensign, Field Representative for the Florida Tuberculosis and Health Association, worked very closely with Mrs. Cora Bay, part-time executive for the local association, as well as with the other agencies, with teachers, and with the press. Printed materials and films on tuberculosis were sup-



A group of the many adults who turned out at the East Marion school for their check on tuberculosis when the State Board of Health's Mobile X-ray Unit was there. —(Staff photo).

plied for adults and children. Mrs. Ensign worked closely with teachers on the tuberculosis education program preceding and following the x-ray program, in connection with University of Florida visiting staff consultants. Mrs. Bay also kept in close touch with the program in her capacity as county nurse as well as with the tuberculosis association.

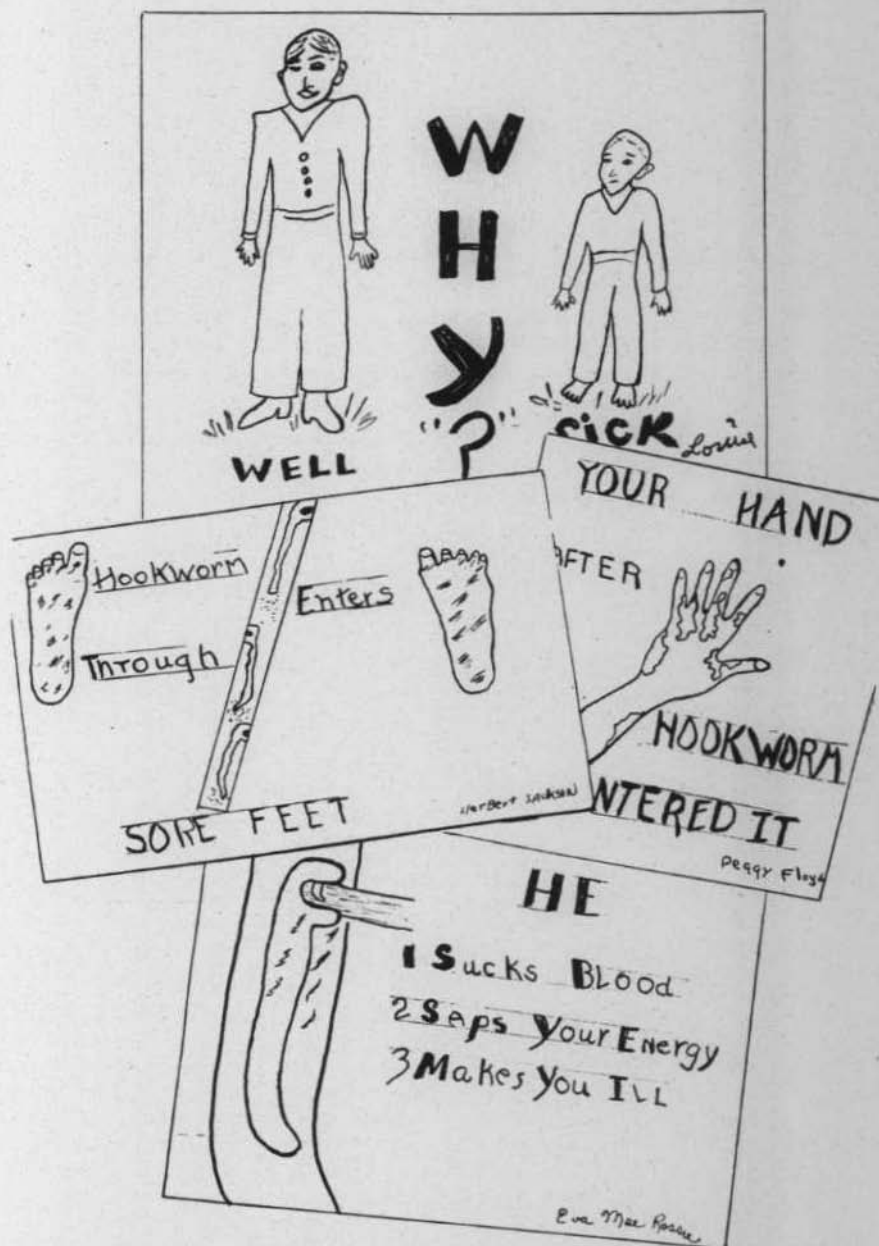
**The School Service Bureau, College of Education, University of Florida:** At the request of the teachers and Mr. Brown, Miss L. E. Jones, School Service Consultant, Mrs. Lillian Hough and Mrs. Grace Adams Stevens, demonstration teachers, assisted in initiating units of study on nutrition, tuberculosis, hookworm and other health problems in the various grades. This included the educational preparation and follow-up related to the examinations. They aided teachers in the selection and use of teaching materials, printed and otherwise, and particularly in integrating health teaching with other learning areas such as the language arts, arithmetic and social studies. These services were particularly helpful to the faculty in their planning, and following through on the very important teaching phases of the program. Guidance was particularly centered around methods for extending to the homes information studied in school. Letters to parents, placards, announcements, home explanations and many other devices were tried.

**The East Marion School:** It would be impossible to list here all of the many things done under school direction on this program. All teachers and every grade in the school worked hard and consistently on the health projects they had undertaken. A school garden was planned and planted in cooperation with the County Farm Agent, each grade having its special plot to plant. Vegetables were related to eating practices.

Each child kept an individual record of his daily dietary for about ten days to two weeks before the nutrition survey and again after the survey. The dietaries were studied in relationship to survey findings. Height-weight growth charts were kept individually by each child. All wrote letters home concerning the nutrition and tuberculosis programs, many in respect to hookworm. Home surveys were made by nearly all children in respect to previous x-rays, home menus, gardens, sources of milk, cows, types of toilet facilities and other problems.

The 11th and 12th grade English classes took the leadership in many respects. They studied and assembled library and other materials, made out bibliographies for use by other grades, worked on a reserve shelf of health materials in cooperation with the librarian, and wrote for additional materials from the State Board of Health and the Tuberculosis and Health Association. Class members wrote, rehearsed and gave talks to the other grades on the health problems of concern. They helped with publicity, helped in summarizing the findings and accomplishments of the other grades as well as their own, helped with compiling a report of the progress of the school program at the end of the year.





Congratulations to Putnam County's Crescent City School and to Miss Elsie Padgett, principal, for their noteworthy hookworm education program. Above are reproductions of just a few of the many poster interpretations drawn by elementary school pupils there.

Findings of the examination programs were studied by this 11th grade group. Menus were written to stress the use of most needed foods. Commercial classes typed and mimeographed the menus and other notices which were sent home to parents. Many posters and handbills were made for use in school and in other community meeting places.

As one culminating activity, the English class wrote and presented before the parents a skit on tuberculosis which was an outgrowth of their work with Mrs. Ensign and Miss Waters, their teacher. The teaching unit which accompanies the film, "They Do Come Back", secured from the Tuberculosis Association, was used in writing the skit. It was particularly successful.

This is but a sketchy outline of merely the major phases of the East Marion program to date. Enthusiasm is high among faculty and students concerning the possible projects for the coming year. Truly the program is just emerging. We expect it to expand into the continuous type of cooperative educational program that is essential before the real solving of health problems is actually begun.

(Editor's note: Splendid, indeed, as were the contributions of each cooperating agency with this project, most credit is due to the teachers of the East Marion School for their constant and hard work and for their fine spirit. On them, of course, fell the day by day work of keeping interest high, of keeping instruction sound, and of following through the many details involved.)

## **WE CALL YOUR ATTENTION TO . . . . A HANDBOOK FOR TEACHERS:**

**TITLED: "PROTECTING THE HEALTH OF STUDENTS"**

**Prepared by:** *Mrs. Genevieve Soller, Consultant Nurse with the Bureau of Public Health Nursing, State Board of Health*

**Published by and for:** *The Pinellas County Board of Public Instruction in cooperation with the Pinellas County Health Department.*

This is but one excellent example of the splendid work Mrs. Soller has done to assist with school health programs in Florida. The HANDBOOK is indeed noteworthy, not only because it is so practical, written clearly and well, but because it is the result of a type of cooperation between local school and public health workers that we hope can be nourished and fostered in every county in the State. Congratulations to Mrs. Soller and to Pinellas County. The HANDBOOK is available on loan from the Library at the State Board of Health. It will serve as a splendid guide for other counties interested in cooperative planning for better school health programs.

(Editor's Note: We hoped to have an article on the Pinellas County school health program for this issue of HEALTH NOTES. We are most disappointed, as we know you are, not only about not having the article itself, but because of the reason: Mrs. Soller's resignation from the State Board of Health. Congratulations to her, however, on her new assignment as Assistant Senior Nurse Officer (R) with the United States Public Health Service. We wish her all success. She and her work will be greatly missed in Florida.)

## IF ONLY ALL TALES COULD BE TOLD . . . . .

Honorable mention, indeed, goes to four other counties whose outstanding school health programs have come to our attention. In these schools, as in those described more fully in this issue, the health programs have been based on cooperative planning and action on the part of school, health department and other community groups. How we wish there were space in this issue for full reports of their achievements:

**PINELLAS COUNTY** . . . . where school superintendent G. V. Fuguitt and health officer R. D. Hollowell, M. D., developed a county-wide program with the aid of Mrs. Gene Soller, Consultant Nurse for the State Board of Health. Public Health nurses, teachers and other groups planned and achieved fine preliminary results in closer home-nurse-teacher cooperation in attacking individual health problems of pupils. (See page , announcing their HANDBOOK).

**MANATEE COUNTY** . . . . where, in the Oneco, Prospect and Samoset schools, J. Hartley Blackburn, new county superintendent, led the way, secured cooperation with many State and local agencies and, with real support from the principals and teachers, stressed needed nutrition, tuberculosis and hookworm education at home and at school.

**ALACHUA COUNTY** . . . . where an attack on nutrition, hookworm and sanitation problems was launched in the Archer and Micanopy schools, on *Aedes aegypti* mosquitoes by all sixth grades in Gainesville, under the joint guidance of the principals and teachers: Howard Bishop, Miss Theresa Graves and Mrs. Mary Philyaw, county superintendent, supervisor and lunchroom supervisor, respectively; Health Officer Frank Hall, M. D., and his staff; P. K. Yonge School instructors, and representatives of several state agencies.

**PUTNAM COUNTY** . . . . where Miss Elsie Padgett's Crescent City School dealt some telling blows to the hookworm. (See posters page ). Mr. Lou Barstow, county superintendent, encouraged the "attack" and many community groups helped. Nutrition was also stressed. A splendid program was begun late in the year as a "warm up" for this school year.

HEALTH PROBLEMS CAN BE SOLVED JUST AS FOOTBALL GAMES ARE WON. ONE QUARTERBACK CANNOT DO IT ALONE, NOR CAN A TEAM OF "QUARTERBACKS", BUT TEAMWORK WILL ROLL UP THE SCORE. FIND THE OTHER PUBLIC HEALTH WORKERS IN YOUR HOME TOWN AND TEAM UP WITH THEM AGAINST YOUR MUTUAL HEALTH PROBLEMS.

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Eighth graders at Glen St. Mary left no stone unturned to "know thy opponent" . . . the Hookworm! Here Barbara Jean Johnson, Wendell Scoles and "Frankie" Thomas prepare blackboard illustrations for their class reports. —(Staff photo).



# *Florida* **HEALTH NOTES**

PUBLISHED BY THE FLORIDA STATE BOARD OF HEALTH

JACKSONVILLE • OCTOBER, 1945 • VOL. 37 • No. 10

**DENTAL HEALTH**



# Florida HEALTH NOTES

ESTABLISHED 1890

Florida's new State Health Officer is Dr. Wilson T. Sowder, appointed by Governor Millard F. Caldwell to succeed Dr. Henry Hanson whose term expired September 15, 1945.

Born and raised in Virginia, Dr. Sowder choose the University of Virginia for his medical studies, graduating in 1932. After his internship at the Iowa City University Hospital he went to San Francisco where he was assistant resident physician at the St. Luke's Hospital.

In 1934 he was commissioned Assistant Surgeon in the U. S. Public Health Service, promoted to Passed Assistant Surgeon in 1937, and finally to Surgeon in 1943. He was stationed at marine hospitals in Baltimore and in Seattle during the years 1934 to 1937 and also during the period he served with the U. S. Coast Guard in Alaskan waters.

The year 1938 saw him at the U. S. Quarantine Station in San Francisco. Next Dr. Sowder accepted the chance for more schooling and was sent to Johns Hopkins University School of Hygiene and Public Health where he received his masters degree in public health in 1939. After that he went to Tennessee where he directed the state's venereal disease control program for a year. Then he came to Florida.

Pensacola claimed him first as VD control officer during 1940 and 1941. From there he went to Tampa where he was VD control officer and later director of the Hillsborough County Health Department. He was made director of the Division of Venereal Disease Control for the Florida State Board of Health in 1942; the next year he became director of the Bureau of Local Health Service and also served as Assistant to the State Health Officer.

He left Florida in 1944 to become consultant in communicable disease control for the War Shipping Administration, later consultant in general public health and venereal disease control for the U. S. Public Health Service's district 9 in Dallas, Texas, where he stayed until called back to Florida this summer.

Dr. Sowder's wife, Lucille, two children, Tommy and Martha Jane, ages 8 and 5 respectively, have joined him in Jacksonville where they are making their home.

We want to take this opportunity to welcome them again to the State and to wish Dr. Sowder much success as Florida State Health Officer.

# *The State Board of Health*



WILSON T. SOWDER, M. D.



The Dental Health bureau stresses cooperation with local groups wherever its dentomobiles are stationed. In fact, the results of such cooperation have been almost indispensable during the past dark years when help of any sort has been at a premium. Here, Mrs. L. W. Martin, executive secretary, Highlands County Tuberculosis Association, is registering a young Sweater Girl, next in line for a checkup by Dr. J. E. Urich, dentist in charge of the trailer. —(Staff photo).

# DENTAL HEALTH EDUCATION FOR YOU

by **D. H. TURNER**, *Director*  
*Bureau of Dental Health*

Data released by Selective Service placed dental disease in the first rank as cause for lowering the physical status of selectees examined throughout the nation. If the next generation is to escape such a stigma, it is necessary that all dentists, public health workers, parents, teachers and school children combine their efforts intelligently to correct the present prevalent situation.

In any plan for preventive dentistry, an educational program is of prime importance. So, from the time of its inception in 1936, the Bureau of Dental Health has used the most feasible means at its command to give dental health education to the state's entire population in an interesting and effective manner. In doing this, the Bureau has directed most of its energies toward children's dentistry; for eventually the state's dental health must rest upon adequate preventive and corrective treatment for children.

Cross-section surveys of the state's population indicate that:

1. Four major factors contributing to dental deficiency in our state are: 1, lack of dental health education; 2, inadequate dental facilities; 3, lack of ability to pay for dental services; 4, no or little provision made for providing dental services to those persons unable to obtain it by their own resources.
2. Between 80 and 92 per cent of the school population are victims of dental disease.
3. Only approximately 20 per cent of the elementary school population is able to pay for dental service against 35 per cent definitely unable to pay anything, and 45 per cent doubtful of ability to pay.
4. Ten of Florida's 67 counties have no dentists or dental facilities whatsoever, thirteen of them have only one dentist each; also the majority of the dentists are concentrated in the cities—leaving large rural areas to overcome the ill effects of dental disease as best they can.
5. In few communities is adequate provision made for giving dental care to dental indigents and near-dental indigent maternal cases, preschool and school children.

Florida's elementary school enrollment (1943-44 record) was 237,657. Naturally it will be larger this fall but by taking that same figure and using our survey measuring rod, at least 202,008.45 of them will be afflicted with dental disease and of that number only approximately 40,401 will be able, through their own resources, to afford the dental care necessary to alleviate or correct the condition.

The usual media for providing dental health education are distribution of dental health literature, presentation of films and slides, lectures and talks, exhibits (these have not been used since 1942 because of wartime restriction on large gatherings), and demonstrations, corrective clinics conducted for the benefit of the underprivileged among maternal and preschool cases and elementary school children.

The demonstration clinic—combining educational and correctional features—is by far the most effective method of health education. By it a community and its key persons are shown the need for locally maintained and operated dental health programs which will provide dental health education to its entire population and corrective care to the underprivileged among the prenatal and postnatal cases and to the preschool and elementary school children.

For conducting such clinics, the Bureau for the past three years has maintained and operated a dentomobile. The dentomobile, a complete dental office on wheels, can be set up on any location where running water and electricity (110 volts, a.c.) are accessible. Lack of funds and personnel has made it almost imperative to confine these clinics to counties with organized health departments, as the assistance given by the health department enables the handling of more individuals within a given time. For the year ending June 30, 1945, eleven counties had the benefit of the clinic and approximately 7,000 dental services were rendered to 2,345 patients. These splendid results were obtained by operation of the clinic for less than nine months by one dentist working without a dental assistant.

It is expected to more than double these accomplishments for the current year as two dentomobiles will be operated by this Bureau after September 1, on a full-time basis if another dentist can be secured. If the additional dentist cannot be employed, then one dentomobile will operate on a full-time basis and the other one will be used by the director to





Dr. Drew H. Turner, director of the State Board of Health's bureau of Dental Health takes an occasional turn in one of the Bureau's dentomobiles complete dental offices on wheels. One of his "gospels" is to explain the "Why and wherefore" to children, thus relieving possible nervousness and sometimes home-instilled fear of the dentist. The expression on the faces of his young audience would indicate his success with the group. —(Staff photo).

conduct the clinic on a part-time basis in communities adjacent and near to headquarters.

Postwar plans include the operation of six dentomobiles—each staffed by a dentist and a dental assistant, thus maintaining a comprehensive, year-round, state-wide dental health program.

One of the six dentomobiles will be staffed by Negroes and operated for benefit of Negroes. In all instances, the educational phase of the clinic is open to anyone desiring it, while the correctional feature is provided only for the dental indigents among the maternal (prenatal and postnatal) cases, preschool and elementary school children.

## JOHNNIE DRINKS HIS MILK— WHY DO HIS TEETH DECAY?

by **VERA W. WALKER,**  
*Nutrition Consultant*

This is a good question which dentists and nutritionists would like to be able to answer honestly and objectively. But it isn't that easy.

Study of the relationships between diet and dental health is relatively new, as dental history goes. It has been only some twenty-five or thirty years since we first recognized that diet has anything at all to do with the quality of teeth and their resistance to decay.

Since tooth decay is one of the commonest ills of man, people are always interested in any possible cure or prevention. So, since 1917, when Lady May Mellanby, working with dogs, showed that vitamins A and D, and the minerals, calcium and phosphorus, influence the quality of teeth, a great many studies have been made. We still do not know the full story, but there is much we do know.

★ During the period when a child's teeth are forming—which means the last six months of prenatal life and at least the first twelve or fourteen years of childhood—his nutrition is extremely important. His mother's diet should contain adequate amounts of calcium and phosphorus, and of vitamins A, C, and D before his birth. During childhood he needs the same food nutrients for his developing teeth. Milk, fish liver oil, and fresh fruits (especially citrus, tomatoes, and guavas) supply these needed elements. Of course he needs a diet adequate in all respects for his total development, but calcium and phosphorus, and vitamins A, C, and D are the food nutrients most essential to good tooth formation.

There has been recent interest in the part which fluorine plays in the hardness of teeth. This is discussed by Doctor Urich in an accompanying article.

★ Once the child's teeth have formed, his diet has little to do with their composition, but it may affect decay in other ways. Sugar especially, but other carbohydrates also, form acids in the mouth which tend to



Down in Miami no stone is left unturned in the educational phase of maintaining the dental clinic. Dr. David H. Oser never misses an opportunity to explain to his small patients exactly why they should eat the last shred of their spinach or to chomp a fat, raw carrot every now and then. Here is Louise Partin, assistant, pointing out the reasons why the interested young lady at the right should eat some of "all" those vegetables she doesn't like.

—(Staff photo).

dissolve tooth enamel. They also foster the growth of certain bacteria thought to be responsible for tooth decay. There is evidence that tooth decay is hastened by the sugar or the mild acid (or both) in bottled soft drinks.

Teeth and gums need the physical stimulation which chewing gives. A diet containing too many soft foods is not conducive to firm gums and sound teeth. We need a happy medium, combining some foods which have been cooked with some which are firm and chewy.

★ Several of the vitamins are essential to mouth health in general. Without sufficient vitamin C, gums become swollen, red and spongy, and bleed easily. Inadequate amounts of the B vitamins may lead to soreness of the tongue. It may become shiny and red, or purplish with soreness at the tip or of the entire tongue. Lips may crack, especially at the corners of the mouth, and the person may become more susceptible to infections such as Vincent's Angina (trench mouth).

So, even though Johnnie drinks his milk, his total diet may not be conducive to good mouth health. It takes more than milk during the growing period to produce teeth which do not decay. An all-round good diet containing milk, eggs and meat, fruits and vegetables, and whole grain cereals with plenty of sunshine or fish liver oil, but with very little refined sugars, during the time Johnnie's teeth are forming (and the same diet for the rest of his life) will help him to have good teeth. There are undoubtedly other dietary factors yet to be discovered which contribute to mouth health.

There are many interesting books and articles on the relationships between diet and teeth. The State Board of Health library has collected a few of these which we recommend to those who are interested in this problem. Two books, **JUVENILE DENTISTRY**, by Walter C. McBride, and **YOUR TEETH, THEIR PAST, PRESENT, AND PROBABLE FUTURE**, by Peter J. Brekhus, are readable. Three articles on teaching nutrition and dental health are:

Rose and Bosley: "Feeding our Teeth" (a teaching unit for elementary school teachers) Bureau of Publications, Teachers' College, Columbia University, 1940.

Long Jollie: "Teaching Dental Nutrition to Elementary School Children" *Dental Health*, November, 1944.

(Continued on Page 162)

## FLUORINE —

### WILL IT KEEP THE DENTIST AWAY

by J. E. URICH, D.D.S., *Field Dentist*  
*Bureau of Dental Health*

In recent years, many newspapers and other publications have carried articles calling attention to the fact that in certain areas in some of our northwestern and southwestern states the incidence of dental caries is virtually non-existent.

The growing importance that this subject has acquired in relation not only to dental health but to public health in general is evidenced by the questions asked in regard to it. Laymen, as well as the dental and medical professions and scientists, are all interested. Investigations have been in progress for sometime in an effort to learn why in some localities children living under comparable conditions can be separated into two main groups: 1, those only slightly affected with dental caries; 2, those affected with a high degree of dental caries.

It was first thought that the hard waters had something to do with this. It is now generally known and agreed by our scientists that this unusual condition is linked with an element known as fluorine which is found in varying degrees in many water supplies. From the dental examinations made and the experiments conducted, it has been learned that when the fluorine content of a water supply is one part per million it is very beneficial to the teeth during their formative period (birth to about fourteen years of age), but excessive amounts of fluorine—anything over 1.5 parts per million—are harmful. The continual users of a water supply, if they are under fourteen years of age, will have teeth with the enamel stained from light gray to dark brown. This condition is called mottled enamel or dental fluorosis.

The first information that we had on mottled enamel in the United States was about 1908. Dentists from Colorado reported it and called it "Colorado Brown Stain." They observed it in their patients who had a history of continuous residence there from birth or had moved there when their teeth were in the formative period; whereas, other residents who moved to these locations after the formative of their teeth did not



have such stains, nor did they develop the stains even though they had lived there for a number of years

In some of our Florida waters, the fluorine content runs as high as 1.9 parts per million. In other sections there are no traces of the element at all. In those areas where the fluorine content of the water is high, mottled enamel is found on the teeth of the natives. In many sections where the water has no fluorine content, the teeth of the natives are highly carious; and in other districts where the drinking water supply is surface water or rain water, the charts on the mouths of the natives indicate an exceedingly high rate of decayed, filled, and missing teeth—as high as any group of natives in the United States living under comparable conditions.



This is a picture of a Florida school girl who lives in a section where there is too much fluorine in the drinking water. Note the mottled effect on the teeth. Fortunately, say engineers, there are only a few such sections in the State.

—(Staff photo).

In a number of states, certain communities are experimenting with the addition of 1.0 part per million of sodium fluoride in their communal water supplies. Before doing this, very careful charts were made on the mouths of children from twelve to fourteen years of age, inclusive, who had lived in the particular districts continuously since birth, and each year the mouths of the children reaching twelve years of age likewise will be charted. Hence, after observing and checking results over a period of years, very definite information on the preventive value of fluorine against dental caries should be available.



We've heard of circus show-offs sticking their heads in lions' mouths, but here's the pay-off. The jumbo set of molars Dr. J. E. Ulrich is holding is a part of the dental trailers' equipment used in the instructional phase of the dental health program. But Dr. Ulrich entered into the spirit of play when this little girl from Sebring, Highlands County, revealed that a playmate had dared her to stick her head in the "mouth." Nothing happened of course, (fortunately), and its dollars to doughnuts that this is one youngster who will be less nervous the next time she visits the dentist. Amused playmates stand by "just in case."

—(Staff photo).

It would appear from other experiments already made, that adding non-toxic doses of fluoride to a fluorine-free public water supply would be one solution to the problem of preventive dentistry. Reports of studies on this subject indicate that when fluoride is ingested in a concentration of one part or less per million of water, no harmful effects have thus been discovered. This method of dental caries control, however, would not reach all the people as it is seldom that the entire population of the same locality use the same drinking water supply. In many Florida communities, scattered families will be found who use surface water, which is almost free of fluoride, as their main water supply; in other sections, many persons will use rain water, which is practically free of all minerals, for drinking purposes.

At this time, in many parts of the country, experiments in topical application by various methods are under way. These are being closely watched; however, as they are still in the most preliminary state, it is far too soon to evaluate the feasibility of the procedure.

Dental caries, one of the unsolved health problems—and one of the most important—apparently will never be controlled by education and dental treatment alone; therefore, some means must be found whereby freedom from this disease will be open to the entire population. Will it be by adding fluorine to all drinking water supplies? or by topical application? or some other method, as yet unknown? Who knows!

#### JOHNNIE DRINKS HIS MILK—(Continued from Page 158)

Bovee, Dorothy: "Teaching Nutrition to Dental Assistants" *Dental Health*, May, 1944.

The above are available on loan and also some more or less technical articles which cover the subject quite adequately:

1935—Jones, Martha R.: "Our Changing Concept of an Adequate Diet in Relation to Dental Disease." *Dental Cosmos*, June, July, August, 1935.

1938—Radusch, Dorothea: "Diet During Childhood" *Journal of the American Dental Association*, 25, 122, 1938.

1938—Krasnow, Frances: "Nutrition Influence on Teeth" *American Journal of Public Health*, 28, 325, 1938.

1944—Mann, Arvin W.: "Nutrition as it Affects the Teeth" *Medical Clinics of North America*, 27, 545, 1944.

1945—Roth, Harry: "Vitamins as an Adjunct in the Treatment of Disease" *Journal of the American Dental Association*, 32, 60, January, 1945.

1945—Schour, Isaac: "The Effects of Dietary Deficiencies upon the Oral Structures" A series of articles appearing in the *Journal of the American Dental Association* for June, July, and August, 1945.



Shown here are glimpses of three fulltime local health, dental clinics. Clinics are open to school children, indigent prenatals, postpartums, as well as indigent adults. —(Staff photos)



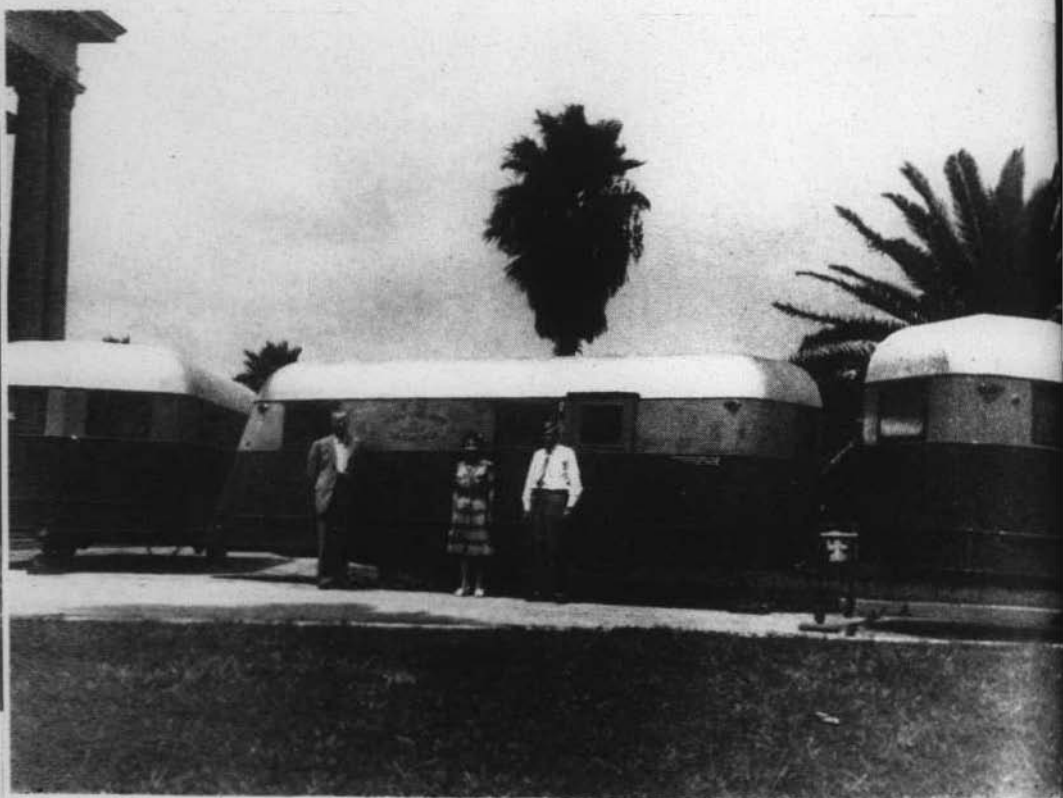
At top is Dr. Frank S. Palik, Pinellas County Health Department, St. Petersburg. His little Negro patient seems to be a pretty good assistant. At least, he is able to show where it "hurts."

Next is Dr. John J. Costa, Hillsborough, with his assistant Mary Edna Myer. Third picture introduces Dr. David H. Oser, Dade County, and you can surmise your own caption. Suffice it to say that he has two very interested school-age converts.

—(Staff photos)



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D40



The three completely equipped dental trailers operated by the Bureau of Dental Health (one belongs to Alachua County) are shown lined up in the shadows of the State Board of Health's beautiful colonade. Standing in front of the center dento-mobile are proud director, Dr. Drew H. Turner, Miss Elizabeth Spears, secretary, and Dr. J. E. Ulrich, whose deft manner with children is his stock-in-trade in the county-front dental programs so proudly hailed by the Florida Dental Association.

—(Staff photo).





## *Florida* **HEALTH NOTES**

PUBLISHED BY THE FLORIDA STATE BOARD OF HEALTH

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**PREMATURE BABIES**

# The State Board of Health

Hon. Millard F. Caldwell  
Governor of Florida

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## PREMATURE BABIES

Of the 51,654 infants born alive in Florida in 1944, 755 were reported to have later died because of premature birth. This means that out of every thousand babies born alive, between 14 and 15 die because they were born before term.

For a number of years premature birth has held eighth place among all causes of death in Florida. A chart in this issue shows that there has been a gradual decline in these deaths over the past 10 years. But still the rate is far too high.

Until the public, generally, becomes aware of the problem, the premature death rate will continue to be too high. We must strive to understand the causes of premature birth, in order to prevent or cure them, and thereby reduce the number of babies born prematurely. Also we must understand the reasons why premature babies die, in order to save as many of them as possible.

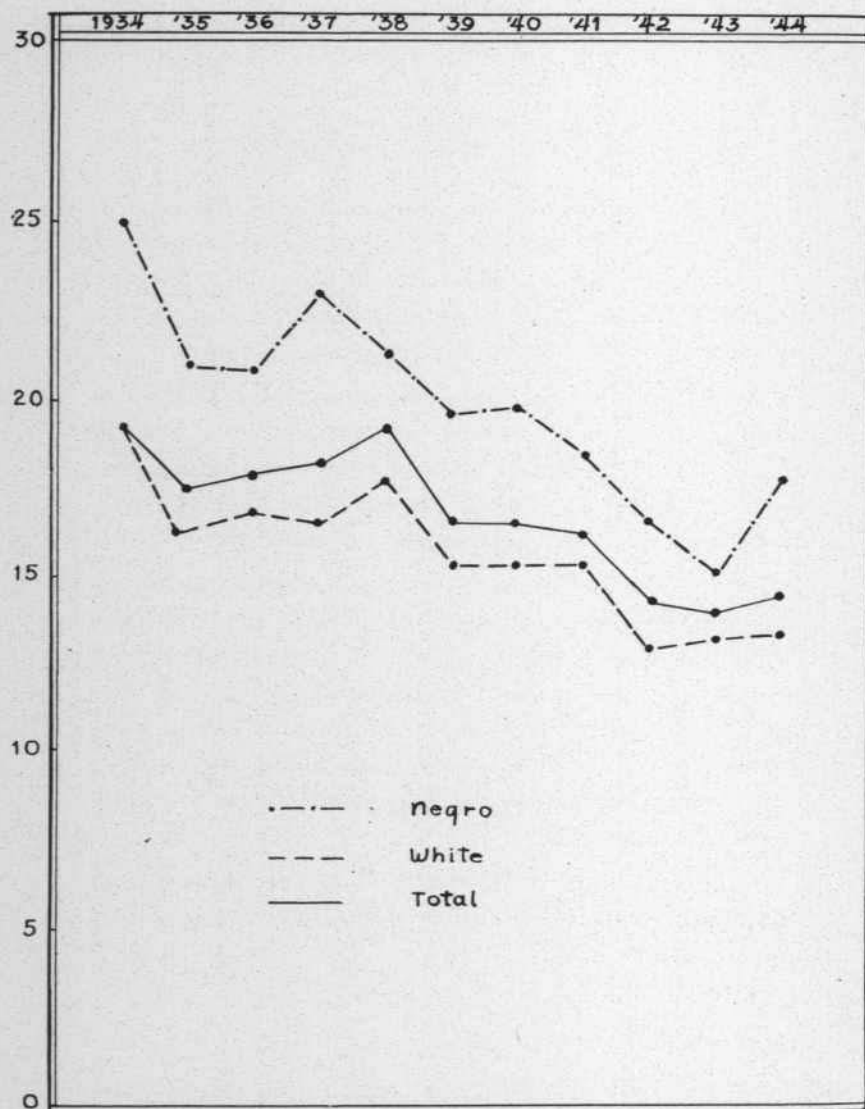
It is not a problem for the doctors, nurses, and hospitals alone. It should be a challenge to us all.

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Rate of Deaths from Premature Birth per 1,000 Live Births, Florida  
1934-1944

# PREMATURE BABIES

**EMILY H. GATES, M. D.,** *Acting Director*  
*Bureau of Maternal and Child Health*

## THE PROBLEM

First of all, what is meant by the term "premature infant"? For simplicity's sake, let us say it applies to any infant weighing less than 5½ pounds at birth. Most of these small infants have been born weeks or even months too early. However, occasionally even a full term baby will be small enough to fall in this group. We may call it "immature" instead of "premature," but essentially there is little difference. The characteristic common to both is that they were born before they were completely ready for life independent of the mother.

Many factors will determine the ability of such a child to live. The smaller it is at birth, the poorer are its chances of survival. Under the best conditions, only a few babies with a birth weight below 2 pounds will live. Length of intrauterine life is also important. For example, the baby born only a month early usually gets along better than one who is six weeks premature. The cause of the mother's premature labor is important, too. A baby born ahead of time because of some sudden shock to a mother otherwise in good health will more likely survive than the infant whose mother went into labor prematurely because of a toxemia of pregnancy.

**But what, you wonder, causes a child to be born prematurely? Which of these causes can be prevented, and how?**

Some babies are born prematurely because of defects within themselves. These infants rarely live. Perhaps it is nature's way of eliminating the unfit. Others are born prematurely because of chronic disease of the parents, such as syphilis or tuberculosis. Conditions which affect the mother's general health may cause early labor: malnutrition, severe anemia, overwork, and acute illness should be listed here.

In Florida, where toxemia heads the list of causes of maternal deaths, it is also responsible for many premature births. (These infants seem particularly difficult to save.) Local conditions in the mother can cause labor to begin early. Among them are tumors of the uterus, a condition associated with bleeding called placenta previa, and certain conditions which interfere with the baby's circulation, such as pres-



sure on the cord or premature separation of the placenta. The Rh factor of the blood may also explain cases of premature birth, particularly after the first baby. Sudden shock, mental or physical, may hasten the onset of labor. Twins and other multiple pregnancies are very often the cause of premature labor. Moreover, the babies are usually rather small and often quite immature.

**Good prenatal care would prevent many of the premature births occurring today.** Women who consult a physician early in pregnancy and then follow his instructions throughout the pregnancy may still go into premature labor, but they are less likely to do so. Good prenatal care will discover and treat cases of syphilis, protecting both mother and infant. The mother will be given sound advice about diet, and if she is anemic, this will be discovered and corrected. Good prenatal care is essential in preventing toxemias, including the dread eclampsia. The physician may discover signs of trouble before the mother is aware that anything is wrong. Often he can help her to carry her baby to full term; even when this is impossible, he can usually see that proper arrangements have been made for the care of the premature infant about to be born.

As people, generally, come to understand the purpose and value of regular prenatal care, fewer mothers will develop conditions which cause premature birth. If we can prevent a considerable number of children from being born prematurely, half the problem will be solved!

**Meanwhile, let us consider the ways in which these small infants differ from others, requiring special care.**

In appearance they are thin and wrinkled. The skin is thin and translucent, with little fat beneath it.

Breathing is often feeble, partly because the nervous system is underdeveloped, and partly because the respiratory muscles are still weak. If mucus or milk gets into the windpipe, the baby has trouble dislodging it.

Wide fluctuations in temperature are characteristic. An incompletely developed heat-regulating center is partly responsible. Loss of heat is excessive, too, because the skin surface is relatively large for the size of the baby. There is little subcutaneous fat, and the skin is thin with many small blood vessels near the surface. Then, too, the tiny infant is unable to take in large amounts of fluid and nourishment to maintain its own body heat.

This inability to take and digest adequate amounts of food constitutes another major difficulty. Parts of

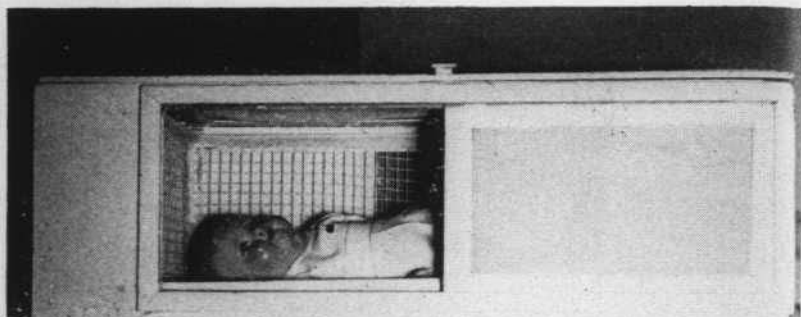


The tiny bundle in this improvised incubator is getting oxygen from the nearby tank. Like many others arriving in this world under the heading of "premature", he needs it in his desperate fight for life. The picture was made at the Tampa Municipal Hospital. Margy Anne Howe of Clearwater, senior student at the Gordon Keller School of Nursing, checks the progress this three pound mite is making in his determined struggle against pretty serious odds. Note Miss Howe's gown and mask, parts of the careful technique employed to protect these delicate babies from possible infection. (Staff Photo)

the gastro-intestinal tract are underdeveloped, the digestive enzymes are reduced in amount, and absorption of food is below normal. Moreover, the baby born at 32 weeks has a stomach capacity of only about 18 cc., or less than half that of the full term infant (45 cc.). The muscle at the upper end of the stomach is poorly developed, so the infant tends to regurgitate part of the food he does take.

Underdevelopment of the nervous system in general accounts for the drowsiness and muscular inertia of these babies.

(Continued on page 179)



State Board of Health technicians put their heads together, designed the above incubator, and had it built by the staff's carpenter. Sliding windows and screens make it possible to observe and care for the infant without removing him from his heated bed. Similar models are now in a number of county health units. (Staff Photo)

Here we show a premature infant—often called “premie” in medical jargon—being placed in a commercial type incubator. The gadget-box for heat control is at extreme lower right. The other picture shows the incubator closed. Senior student nurse Deloris Locklear of the Gordon Keller School of Nursing, Tampa Municipal Hospital, is checking the infant's condition. A number of commercial brands of incubators are available. Circumstances were such that only this particular type could be photographed by press time.

(Staff Photo)



## THE INCUBATOR—A LIFESAVER

Loss of heat has long been recognized as a cause of death among premature infants. There are men and women today who owe their lives to some simple device such as a shoe box lined with soft cotton and kept by the oven door. But for each baby saved by such ingenuity, thousands died who might have been saved in a modern incubator.

Before birth an infant lives in an environment subject to few changes. It is the purpose of an incubator to maintain a constant, sheltered environment for the frail infant which has been born before nature meant that it should be.

It is said that before about 1880 incubators of the modern type were unknown in the care of prematures. Then Stephane Tarnier used one fashioned after a model which had been designed for premature lion cubs at the Paris Zoo.

It is probable that Dr. Martin Couney brought the incubator to this country to stay. He had studied under Tarnier in Paris, and in 1906 opened an incubator station at an amusement park in Chicago. A child specialist who became interested in Dr. Couney's small proteges later devised one of the most satisfactory incubators available today.



Here's a wisp of evidence that premature babies do grow up to be normal healthy people—and sometimes without too much care. Here is the State Board of Health's publicity consultant, Ruth Stuart Allen who weighed 2¾ pounds at birth. Her incubator was a pasteboard box, kept on the oven door for warmth until she was six months old. (Photo by Philips, Hillsboro Health Unit)

We now know that premature infants thrive best in an environment affording not only even temperature but also regulated humidity and, at times, increased oxygen content of the air. As we have learned more about the needs of the premature, incubators have been designed to meet those needs as adequately as possible.

Today there are a number of firms manufacturing incubators which range in cost from slightly under fifty dollars to several hundred dollars. Some of them are so constructed that the baby need not be removed even for feeding or dressing. They are equipped with devices for the control of temperature, humidity, and oxygen concentration—one might call them closed units, completely air-conditioned. Others are constructed much like a box from which the bottom has been removed. This type is placed over the infant in an ordinary bassinet. The air surrounding the baby is heated by means of electric bulbs inside the box. A thermostat keeps the air at an even temperature by turning the bulbs on and off as needed. Some of these simpler incubators are equipped with a means of humidity control and a few also have arrangements for oxygen administration.

In an attempt to determine just how adequately Florida is supplied with incubators, a questionnaire was recently circulated by the Bureau of Maternal and Child Health. It was sent to all hospitals (civilian and military) which, to our knowledge, provide care for newborn infants. It was also sent to all county health units.

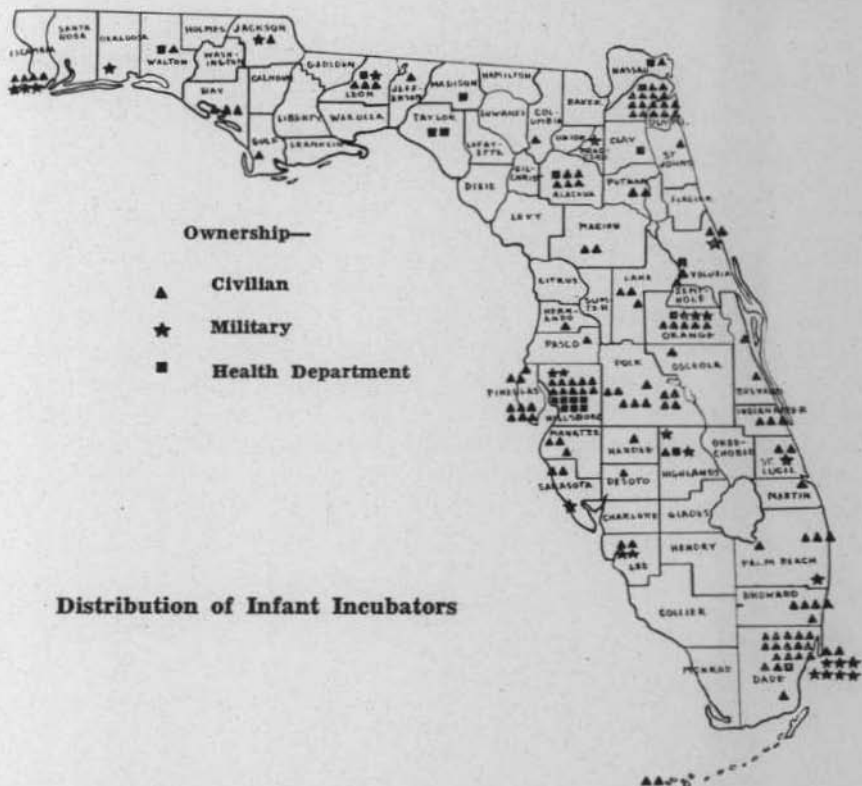
In all, 158 questionnaires were sent, and up to October 2, replies had been received from all but 10.

A total of 180 infant incubators was reported. A map is included in this issue to show, in a general way, their location and ownership. One can see at a glance the strides which some areas have made in providing better care for prematures. It should be noted, however, that in certain parts of the state the only incubators are those provided in military hospitals, for the care of servicemen's dependents. **Of Florida's 67 counties, 43 counties have one or more incubators, 24 counties have none.**

There are 132 incubators located in 81 city, county, or privately owned hospitals. Another 27 incubators are located in 16 military hospitals, and we understand that some of these are property of the Red Cross. There are 21 incubators belonging to 13 health departments. One incubator belongs to a physician who practices in an area having no hospital.

Of the 180 incubators reported, 108 were commercially manufactured, and 69 were of the "homemade" variety. Almost all known commercial makes are represented. Some of the others were made by carpenters and metalsmiths and provide many of the advantages of the commercial types. Still others are very simple devices such as padded baskets or bassi-





nets in which heat from carefully protected hot water bottles is retained by means of a cloth covering over the top. The fact they are kept in readiness for an emergency earns them a place along with all the rest. **The exposure which a premature infant suffers while an incubator is being improvised after his birth may well be the cause of his death.**

A chart in this issue shows that since 1934 the most marked decline in the death rate from prematurity has been among Negroes. This is partly due to the increasing percentage of incubators available to them. Our survey shows that of 180 incubators, 85 are available to Negro prematures. There are 6 commercially manufactured and 4 improvised incubators in hospitals operated solely for Negroes. There are 62 incubators in hospitals operated exclusively for white patients.

We cannot save premature infants with incubators alone. But if there were enough of them throughout the state so that no premature need begin life without one, we could save many more of these infants than we do. It takes money to buy an incubator—and time and ingenuity to improvise a good one—but the dividends run high in lives saved!

## PREMATURE CARE

We have described the ways in which premature babies differ from other newborns. Those differences must be kept constantly in mind when one is planning care.

Perhaps if conditions were ideal, all these infants would be cared for in special centers provided exclusively for them. A few of the larger cities in the country already have such arrangements. In certain hospitals in these cities a section is set aside for prematures only.

Whole rooms are provided with heat and humidity controls, so that the infant's environment will be kept as constant as possible. Oxygen is immediately available for an infant which has a "blue spell" or just doesn't seem to be breathing properly.

Special fluids are at hand, to be given under the skin or by vein to the infant who cannot keep up the necessary intake by mouth. Blood and plasma are also available. Arrangements are made whereby breast milk can be secured for these babies, or a formula laboratory prepares feedings calculated to simulate breast milk as nearly as possible. Equipment for feeding by tube or other special methods is kept on hand.

All persons connected with these centers are specially trained in the care of premature infants. They have been taught that **these babies require constant watching—but should be handled only when absolutely necessary.** They know that if they have a cold or any other infection, they must stay away from these babies, which tolerate even slight infections so poorly.

To avoid chilling enroute, babies are brought to these stations from the delivery room of the hospital in a heated bassinet or portable incubator. Babies born at home are also brought to these centers, sometimes from miles away, in little portable incubators loaned for that purpose.

Usually the death rate from prematurity is considerably reduced in areas served by such centers. It should be. Care by specially trained attendants, in rooms where temperature, humidity, and equipment are all adapted to the premature infant's needs, leaves little to be desired.

Some day Florida will have such centers as these, at least in the more populous areas. We shall be very grateful when the first one is established, because it will be another milestone on the road to better care for premature infants.



Here is Sharon Verneen Howell again, posing in her best Sunday manner to give you an idea how a premature baby can look when she's nearly one year old. Proper care during the critical weeks immediately after birth overcame her initial handicap of premature birth. (Staff Photo)



Now here is one for the book, in the person of John B. Coats, son of Mr. and Mrs. J. B. Coats, Jacksonville. This strapping young fella weighed two and one-half pounds at birth—was a six and one half months baby. We don't believe any discussion of his health and well being is necessary. Just have another look at the picture. Johnnie Boy has shot from 2½ pounds at birth to 32 pounds at 29 months. We don't know whether to congratulate his parents or sympathize with them . . . He's six bundles rolled into one and a delightful chore to tax both mental and physical capacities. (Staff Photo)

**Meanwhile, let us consider the things which are already being done in Florida to improve our situation.**

As you have already read, 81 civilian hospitals now own 132 incubators. Several others have placed orders and should have incubators before long. In a few of the larger hospitals a separate nursery room is provided, where only premature are kept, in their incubators.

The Bureau of Maternal and Child Health began some time ago to distribute incubators of simple but efficient design to county health units. These incubators can be carried anywhere in an automobile and can be used in homes with or without electricity. They are particularly useful in rural areas, where most babies are born at home and must be cared for there, even though they may be premature.

Along with the distribution of these incubators, a number of lectures on the "*Care of the Premature Infant*" have been given to groups of public health nurses. This issue contains a picture of the group which attended the seminar given by Miss Johanna L. Sogaard at the Seminole Hotel in Jacksonville in September. Miss Sogaard had recently completed a postgraduate course at Presbyterian Medical Center in New York and had much helpful information to give.

When a premature baby is born at home, the family is often completely at a loss to know what to do. It is not always possible to take the child to a hospital, because of transportation difficulties, crowded hospital conditions, or lack of funds. The doctor, midwife, or family, confronted with such a situation, often turns to the public health nurse for help. It is she who will provide them with a health department incubator if one is available in her county, or improvise a satisfactory one if necessary. She will teach some responsible member of the household how to use the incubator and instruct them in the details of feeding and caring for the infant. She is a very busy person, with many other duties to perform, but to her the arrival of a premature infant constitutes an **emergency!** Without the help of the public health nurse, many more premature infants would be lost.

The fact that Florida has already achieved results in its attempt to improve conditions for premature infants is proved by statistics. **The death rate has dropped from 18.4 per 1,000 live births in 1934 to 14.6 per 1,000 live births in 1944.** Special training in premature care for hospital and public health

nurses has been one factor. Increased use of incubators in the hospital and the home has played a part. Moreover, during the same period medical science has given the physician a better understanding of infant feeding, the use of blood and plasma, the value of certain vitamins, and the control of infection.

These factors, together with better public understanding of the problem, should maintain the general downward trend of the premature death rate.

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**PREMATURE BABIES—**(Continued from page 171)

There is a tendency toward hemorrhage, and the development of a serious degree of anemia unless steps are taken early to prevent it.

Premature infants are more prone than others to develop vitamin deficiencies, such as rickets and scurvy.

Their resistance to infection is so low that even the slightest infection may cause death.

In other words, a premature infant is not just a smaller edition of a normal, full term baby. He has a poorly developed nervous system, heat regulating mechanism, respiratory center, and digestive system. He was born before he had time to acquire a proper store of iron and vitamins from the mother. He becomes infected easily and has little resistance to fall back on. If he is to be saved, special attention must be directed toward all of these shortcomings.

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**COVER PICTURE**

Sharon Verneen Howell, daughter of Mr. and Mrs. T. D. Howell, Jr., Jacksonville, caught the welcoming committee off guard by arriving in this Vale of Tears a month too early. Weighing only four pounds, she was not to be discouraged; squared her tiny shoulders and set about the serious business of surviving. Today, at the age of 11 months, she has admirers exclaiming "would you believe it?" She looks inquiringly through the bars of her crib and reports: weight 23 pounds, height 29 inches, all of which inspires a glowing pride in those concerned with the welfare of one Sharon Verneen. (Staff Photo)



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Supervising nurses from the local health units meet periodically for a general pow-pow and program-comparison-meeting. This picture was made at their September conference when Johanna L. Sogaard (hiding in the background) shared her information on the care of premature babies, gleaned recently at the Presbyterian Medical Center, New York City.

(Staff Photo)



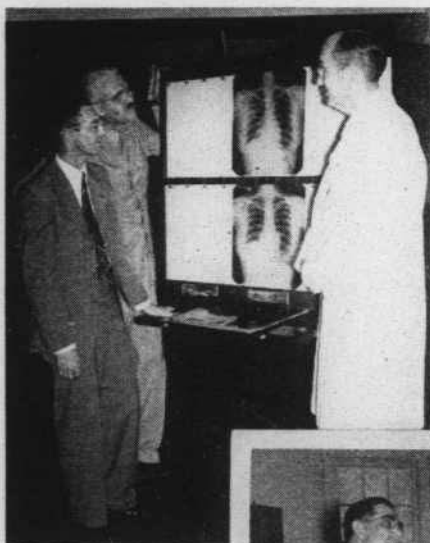
*"Florida needs more Sanatoria like this one"*

# *Florida* **HEALTH NOTES**

PUBLISHED BY THE FLORIDA STATE BOARD OF HEALTH

JACKSONVILLE • DECEMBER, 1945 • VOL. 37 • No. 12

**TUBERCULOSIS**



This picture was one of those "sneak surprises" made at the annual Tuberculosis conference at Orlando last winter. We see Dr. E. J. Teagarden, director of the State's Tuberculosis Control Division earnestly studying two x-ray pictures with Dr. C. W. Sharp, USPHS, and Dr. R. D. Thompson, Superintendent of the sanatorium.

(Staff photo).

First community-wide x-ray program sponsored by the State was held at Port St. Joe early last winter. Particularly are the civic clubs and City Fathers to be congratulated upon their efforts to bring out a representative group for chest pictures. Here we see Mayor Sharitt getting ready for his x-ray, chatting with Dr. H. A. Russakoff, first physician sent to Florida by the U. S. Public Health Service when they lent the State Board of Health a movable x-ray unit. (Staff photo).

Down in Marion County at East Marion School Joe E. Brown, superintendent, floated a real health education campaign which even extended to the parents over the countryside. Grand finale was the arrival of the State Board of Health's mobile x-ray unit with every boy and girl over 15 years of age reporting for chest pictures. Here we see technician Moorehouse giving an interested group some pointers about the importance of finding TB in its early stages. Representing the Tuberculosis Association on the job was Miss Grace Ensign.

(Staff Photo)

# Florida HEALTH NOTES

ESTABLISHED 1890

## TUBERCULOSIS

Tuberculosis stands in the forefront among Florida's many health problems today. The substantial progress made in reducing the number of cases of this disease and the deaths therefrom during the last half century in this country as a result of a moderate and not always concerted campaign against it, leads us to believe that a vigorous and concerted drive can within a reasonable length of time very nearly finish the job that was started long ago.

Such a drive must have several features. There must be case finding. The technique of taking small x-ray films on a mass basis promises to solve this problem. Cases found must be brought under medical care. This usually involves hospitalization and this is expensive, but Florida shows signs of willingness to bear this expense. There must be clinics for diagnostic purposes and to give pneumothorax treatments to selected cases.

A constant educational campaign must be carried on, not only to keep the general public informed of this problem, but each patient must be taught the best methods not only of caring for himself, but also of preventing the infection of others. This must be done not only in the clinics, hospitals and sanatoria, but also in the home itself. The importance of the patient's being hospitalized at the onset of the disease must always be stressed. Unfortunately, Florida does not have sufficient hospital beds for all of the cases, and it is to serve these citizens who must be cared for in their homes that the county health units send their public health nurses to teach the proper technique for home care of the patient. Even though every precaution be taken in the home, much better care can be given by those with training and adequate facilities.

The State Board of Health is committed to an all-out campaign against this disease and will cooperate actively with all official and voluntary agencies taking part in it. It is our belief that the prospect for speeding up the disappearance of this plague is the brightest in the long history of this most worthy movement.

WILSON T. SOWDER, M. D.,  
State Health Officer.

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## TUBERCULOSIS CASE FINDING IN A RURAL AREA

*As reported by F. M. HALL, M. D., Director, Alachua County Health Department, LAURA D. TUCKER, R. N., Executive Secretary, Alachua County Tuberculosis and Health Association, CLYDE BEALE, Assistant Agricultural Editor, University of Florida, LOUISE KINCAID, R. N., Director of Nurses, and HELEN H. LYNAUGH, R. N., Director of Nurse Trainees, Alachua County Health Department, Gainesville, Florida.*

When a case finding program is being considered in a county, due to the magnitude of the undertaking, all agencies and organizations must lend their active support if the program is to be successful. There are three groups that are directly interested in each county, namely: the medical profession, the tuberculosis association and the local health department. From these three groups must come the leadership for such a program. The medical profession must not only be willing but must actively support the program. Without the active support of the physicians in the area the program will be a failure. To secure the effective support of the medical profession the director of the local health department should assume the responsibility. The medical society should be approached early in the planning of the program. If the profession is given an opportunity in the planning of the following three points the program will have the physicians' support.

**These points must be approved by the medical groups:**

Eligibility of persons to be x-rayed. It should be agreed that all persons who have reached their fifteenth birthday be offered an opportunity of this diagnostic service.

Method of reporting x-ray findings as to

(a) Negative findings

The health department should report in confidence all negative findings directly to the person concerned.

(b & c) Suspects and positive cases

The report of suspects and positive cases should be mailed to the family physician and the case or suspect requested by mail or by a nursing visit to report to his physician.



## Follow-up of cases, suspects and contacts.

- (a) The follow-up on cases is to be made by the health department to see that the persons concerned are under medical care and to instruct them how to avoid spread of the disease.
- (b) Suspects. The health department should assume the responsibility, at the discretion of the family physician, of establishing a definite diagnosis.



The x-ray survey held in Jacksonville a few months ago was devoted to industry, rather than to community-wide campaigns currently being pushed over the State. Here we see three well known union officials, D. W. Millan, M. G. Boyce and Alfred Bolster, who not only called upon their personnel to have their chests x-rayed, but reported for pictures themselves. On steps is technician Morehouse, and next is Dr. E. J. Teagarden, director of the State's Tuberculosis Control Division. (Staff photo).

- (c) Contacts. The health department is to assume the responsibility to x-ray and protect these contacts by health teaching.

**There are two sources of x-ray service for communities:**

Bureau of Tuberculosis Control of the State Board of Health.

United States Public Health Service.

A request for this equipment should be made directly to the Bureau of Tuberculosis Control of the State Board of Health.

The method of choice in a case finding program is portable x-ray apparatus with the operation cost low enough so that the x-ray service may be offered the general public. In securing the equipment, one must bear in mind the need of the follow-up on the 14 x 17 in. x-rays. Some miniature type equipment can be converted to 14 x 17's; others do not have these features and would require different equipment to do this follow-up. It is essential to procure this equipment prior to the beginning of the miniature survey, so that the delay between reportings of miniature and 14 x 17's is reduced to a minimum.

The prompt reporting of findings is an essential part of the well planned program. Not over two weeks should elapse before the individual is notified of the x-ray result. Reports of negatives should be made as promptly as those of suspected pathology. To those cases showing suspected pathology, a letter of notification and appointment for the 14 x 17 plate is sent. The interval of time between the original and large x-ray must be short in order to maintain the public and the individual interest. Additional clerical help in the health department is necessary in order to keep the reports flowing smoothly.

**After the equipment is secured there are two items of paramount importance that must be found locally:**

Available funds.

The available qualified persons to conduct such a program.

The availability of funds should be a responsibility of the local tuberculosis association and the county health department. In most instances the tuberculosis association will go all the way in providing the necessary funds but they should not be expected nor asked to furnish these funds in the entirety.

The selection of lay personnel should be the responsibility of the local tuberculosis association while the follow-up on the "retakes" should be the duty of the health department.

After the funds, personnel and equipment have



Down at New Smyrna Beach John DeBerry, bank president, and Wm. J. Cozens, executive secretary of the Chamber of Commerce, lead the vanguard for x-rays in the community mass picture campaign. Seated at left recording information about Mr. DeBerry is Mrs. J. Rowley, helper from the Red Cross and to the extreme right, handing the registration card to Mr. Cozens is Mrs. Amy Cason, executive secretary of the East Volusia TB Association. (Staff photo).

Here's a friendly get-together down at New Smyrna Beach, with a member of the Law handing his shootin' gun over to technician Morehouse, while a sanitary officer from the Volusia County Health Department looks on. Both men had x-rays a few minutes later. (Staff photo).

been made available the question of scheduling the equipment must be considered on the following factors:

- Population group to be served.
- Time to be spent in each community.
- Capacity of equipment.
- Electrical requirements.

The time to be spent in each community is dependent, of course, upon the population served and by the capacity of the equipment. The usual capacity of miniature x-ray equipment is approximately 100 people per hour. Time must be given the technicians who operate this equipment to develop and to do the necessary paper work. It is unwise to schedule more than 500 x-rays per day. This should give actual operation five hours with three hours left for developing and doing the paper work. The housing of equipment again is dependent upon the population group to be served. If both white and colored, male and female groups are to be served, then it is necessary to locate the equipment so as to provide a private entrance to the machine for each color and each sex. This may be done in most public buildings by using temporary curtains or with screens.

The electrical requirements are difficult to reach in a rural area. There must be 220 volts with 60 amperes. It is important that the transformer be placed as close as possible and not more than 100 feet from the machine. This is required in order to maintain this 60 amperage without loss during certain periods of the day.

Several days before the scheduled clinic, a competent electrician, under the guidance of the x-ray technician, should set up and test the equipment. The technician, through his knowledge should locate the service outlet.

As in all public health work, unless appointments are promptly and efficiently met, there is a definite loss to the public and to the agency rendering the service.

The electrician is the key person in the whole program. Without him, even the technician is helpless. His

civic-mindedness plus his skill can avert a catastrophe in the x-ray schedule. The electrician should be available on call to the technician during all clinic hours.

The community organization and dissemination of all education materials, schedules, speaking, newspaper, and other publicity, should be the responsibility of the executive secretary of the tuberculosis association. A mass meeting should be called in each community and each town or city for the purpose of explaining the program and to secure working committees. Representatives of all civic and fraternal organizations, medical society, health and welfare agencies, county and city commissions, chamber of commerce, district welfare board, Red Cross, county school board, county agent and home demonstration agent, women's club and any other like groups should be invited to this mass meeting. A committee from this group should be appointed to serve as a central steering committee with the agreement that each appointee would serve in whatever capacity the chairman of the steering committee asks. At the first meeting of the steering committee the chairmen of the smaller committees should be appointed.

RESIDENT DEATHS FROM TUBERCULOSIS (ALL FORMS) AND DEATH RATES PER 100,000 POPULATION BY COLOR, FLORIDA, 1935-1944\*

	TOTAL		WHITE		COLORED	
	Deaths	Rate	Deaths	Rate	Deaths	Rate
1944	789	41.3	362	26.0	427	82.5
1943	842	44.0	366	26.3	476	91.9
1942	867	45.3	368	26.4	499	96.4
1941	927	48.5	364	26.1	563	108.7
1940	973	50.9	375	26.9	598	115.5
1939	931	50.2	371	27.6	560	110.2
1938	1012	56.4	420	32.4	592	118.8
1937	987	56.8	412	33.0	575	117.7
1936	925	55.1	399	33.3	526	109.9
1935	908	56.0	395	34.3	513	109.4
United States 1943	—	42.6	—	34.3	—	112.9

\*Florida State Board of Health, Bureau of Vital Statistics.



**Essential committees are:**

1. Publicity
2. House-to-House Canvass
3. Business House and Industry
4. Institutional and Camps
5. Civic Group
6. Volunteer Assistants
7. Transportation



And here's a picture which the pretty subjects may not think fair to organized technicians. It was made at Gainesville. Circumstances: The unit was set up in a Negro community house. Outside the rain was pouring, and inside there were more than 100 Negro men, women and children of every age—the adults all waiting for x-rays. Just then some tiny gadget in the unit went amuck, and from the expression on the faces of Helen Neely and Dot Fulton it was really time to roll up their sleeves and get under. With a score of persons asking "Is this necessary?" "How much longer?" and a dozen other questions, plus the thermometer standing well over 90 degrees, your photographer couldn't resist the temptation of making the picture. Forgive?

(Staff Photo)

**PUBLICITY**

The quality of publicity rather than the quantity should be stressed. The selected chairman should be a professional person if possible, with the "know how" to contact the newspapers, radio, and the effective public speakers in the community, stimulating in the groups a wholehearted desire to inform the people of the purposes, objectives and progress of a county-wide x-ray campaign. The newspapers and radio stations considering health as a subject of primary interest and importance to the community will cooperate with the program from its inception to its end.

Newspapers that have a county-wide circulation should be used. Articles of from 200 to 500 words in length should be run three or four times a week during the entire program. From information fur-

nished to the editor he should be encouraged to write editorials as often as indicated. Cuts of prominent local persons should be used in connection with the program.

Most of the newspaper articles should be limited to 300 words or less, and a definite attempt be made to bring out some new phase of the program in each. House-to-house canvass, procedure for having pictures taken, clinic dates and time, statements by health leaders, and progress are some of the subjects that should be stressed. No "canned copy" should be used but the local tie-in should always be stressed.

The local radio station can be of great value if the program is directed by a professional. Such programs should be remote control broadcasts from the clinics with the announcer

interviewing the prominent people as well as the average person in attendance; another interesting feature is a "play-by-play" account of a person having an x-ray made, from registration to dismissal from the camera.

R o u n d table discussion with the medical profession, executive secretary of the tuberculosis association, x-ray technicians and health officer is another interesting radio feature. Formal speeches over the air, unless given by professional speakers, are of questionable value. The movie short is of value if is based upon regional or local activities carrying the schedule and hour of the x-ray clinics.

C a r d s should be sent from the tuberculosis association to everyone on the Seal

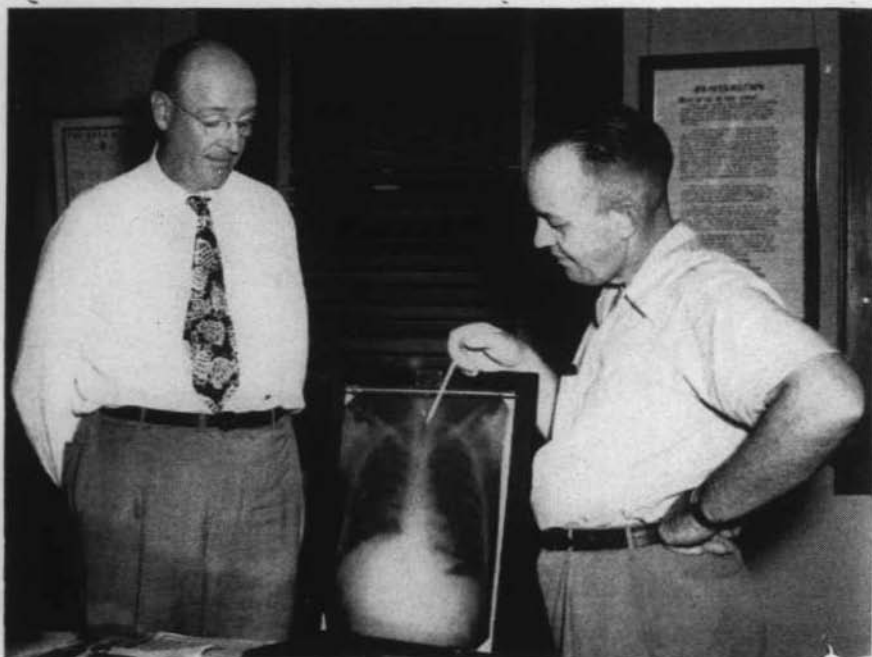


Representation of the Gainesville survey which was worked with the x-ray unit lent by the U. S. Public Health Service and their personnel would be incomplete without a glimpse of the interest shown by the Negroes of the community. . . . As usual, their cooperation was the best and the response of their people especially encouraging. Those in the picture above are leaders in their respective fields. (Staff photo).

Sale mailing list, telling them of the program, urging their cooperation and giving them the time and place of x-raying in their respective communities. Posters calling attention to the campaign should be placed in all business houses. The Boy Scouts are always glad to do the placing of these posters.

### PERSONAL AND GROUP CONTACTS

The chairman of the house-to-house canvass should divide the city into sections. He should ask one person to serve as chairman of each section. Then each sectional chairman should be responsible for securing other workers in her district. This should be so well planned that there will be a personal home call by this group of workers to every home in the community. During this call, a definite appointment slip for each person in the household should be given, the worker retaining a copy to be returned to the office of the executive secretary of the tuberculosis association.



When the x-ray unit first arrived in Gainesville for the county-wide survey, its first stop was at the University of Florida. Here we see Dr. F. M. Hall, right, explaining to Dr. John J. Tigert, president, just how a large x-ray picture is read. Mrs. Laura Tucker, executive secretary of the Alachua Tuberculosis Association, cooperated with Dr. Hall in making the campaign the success they claim.

(Photo by Johnson)

Business house personnel, industrial workers, institutional personnel and inmates, prison camps and other groups should be contacted and arrangements made for institutional or group attendance .

Civic groups when contacted by the chairman will arrange to go in a group from their regular meeting to be x-rayed.

### VOLUNTEERS

The chairman of the volunteer workers needs to have available five or six workers to be at each clinic to serve as receptionists and clerical workers. This help may be secured from the senior Girl Scouts, the Little Women's Club or any other junior group or organization. This group of workers may prepare literature and posters for distribution. Women's clubs

may be asked to serve as receptionists and clerical workers at each clinic session. One person is needed to show the person into the dressing room, another is needed to instruct the women to undress to the waist and put on paper jackets and the men to remove their shirts. Two people are needed to register and another one to stamp x-ray numbers on cards.



One of the promotional phases of the x-ray campaign in Gainesville was a radio broadcast while a line of persons were actually having their pictures made. Here we see Bill Pepper, editor of the Gainesville Sun changing the mode of delivery—from so much type to word of mouth—telling the Alachuans about the importance of getting chest x-rays. (Staff photo)

### TRANSPORTATION

Plans should be worked out whereby transportation will be available to every individual. In some areas school buses may be available to those who do not have travel facilities. If this method of transportation is used a complete county x-ray schedule along with the school bus

schedule should be mailed to every box holder on all rural routes within the county.

In organizing the smaller communities throughout the county, a member of the board of directors of the tuberculosis association who resides in that particular community could arrange for all the meetings, at which time committees should be organized and plans carried out very much as outlined, for both white and colored, depending on the population groups to be served. Although the colored population should be handled separately, it is well that a colored representative be invited to sit in on all white planning committee meetings.



Two other well known Gainesville folks who participated in the survey as well as on the radio program were Clyde Beale who directed the publicity for the campaign and Dr. Lassiter, who before Dr. Hall arrived in Gainesville, was the sole guardian of public health. (Staff photo).



The health department staff should give appointments to tuberculosis contacts and food handlers. In case of negligence to report, this group of individuals should be carefully followed through by follow-up visits by the nurse or sanitary officer.

If all persons connected with the dissemination of news and information in the county recognize the importance of finding tuberculosis or other pathologic conditions early, in order to correct the trouble as soon as possible, and also to protect sound persons who might become infected, they will, as a result of this feeling, extend wholehearted cooperation to the campaign.



There was plenty of cooperation and interest shown by the City and County Fathers when the State's x-ray unit arrived in Gainesville. Here we see Mayor Fred Cone and chairman of the County Commissioners Tom D. Roland finding out exactly how the technical apparatus works. Pretty Helen Neely, on loan from USPHS to the State, is the "head man" or technician when working the machine. The two girls in charge of the x-ray unit, Miss Neely and Dot Fulton, are thoroughly trained and are capable of tearing the outfit down and putting it up. (Staff photo).

## RESULTS OF THE TUBERCULOSIS CASE FINDING PROGRAM IN ALACHUA COUNTY

Applying to Alachua County the general principles outlined, the approach to mass x-ray survey was based upon the factors which comprise the economic geography of the county. Alachua county is located in North Central Florida, about midway between the Gulf of Mexico and the Atlantic Ocean with a resultant equable year-round climate.

The population of 38,607 is mainly rural and fairly stable. Industry plays little part in the economics. Fifty per cent of the population is in six small towns, the largest of which, Gainesville, has 13,000 people or about 1/3 of the total of the county; the remaining population is scattered in villages of 700 to 2,000. About 1/3 of the total population is Negro. The assessed valuation is about \$25,000,000 with a per capita effective buying income of \$480 annually (1942).

Of the total population of 38,607, those eligible for x-ray were 15 years of age and over. Of this group of 27,938, thirty-six and three-tenths per cent or 10,154 availed themselves of the miniature x-ray.

It must be pointed out that this is a rather small group, therefore, any conclusion drawn therefrom would be open to question, but it is believed that there are definite trends. If these trends are comparable with the findings in other areas, then they are of value; if however, the findings do not follow results obtained elsewhere, then further study must be made.

In an analysis of the survey, the evaluation of the principal findings in the white male group is selected as an interpretative example and is shown in Table 1; using Table 2 the population by color is compared. The summary and conclusions in regard to the remaining groups, by color and sex, may be obtained from Table 3 by using a like analysis. All calculations are based upon the eligible population.



Between jobs of x-raying the large groups of persons from industry, the Morehouses, (left) have a friendly comparison of figures with TB executive secretary Frances Moorehead (right) Morehouse is telling Moorehead that she'd better "step on it" if Miami is to break Jacksonville's record of a few months earlier.

(Staff photo).

When the trailer x-ray unit was in Miami last winter doing an industrial survey everybody reported splendid cooperation from both industry and labor. Here are a bunch of "executives" awaiting their turn at the x-ray. They seem happy even though it was necessary to "strip" to the waist on Biscayne Boulevard, before moving into the trailer. Mrs. Frances Moorehead, executive secretary, Dade County TB Association, did the promotion on getting folks out for their pictures.

(Staff Photo)

TABLE 1. TABULATION OF X-RAY SURVEY, WHITE MALE, ALACHUA COUNTY, FLORIDA, JULY-SEPTEMBER, 1945

	Number	Percent
Eligible population	8,227	
Miniature X Rays Made	2,670	32.4
14x17 in. X Rays Made	82	3.1
Definite pathology*	55	2.0
Pathology exclusive of tuberculosis	5	0.2
Pulmonary tuberculosis	50	1.9
Active	12	0.4
Questionably active	20	0.7
Arrested	18	0.7

\*All pathology refers to the chest.

TABLE 2. TABULATION OF X-RAY SURVEY, BY COLOR, ALACHUA COUNTY, FLORIDA, JULY-SEPTEMBER, 1945

	WHITE		COLORED	
	Number	Percent	Number	Percent
Miniature X Rays Made	6,595		3,559	
14x17 in. X Rays Made	176		66	
Definite pathology*	115	1.7	48	1.3
Pathology exclusive of tuberculosis	14	0.2	18	0.5
Pulmonary tuberculosis	101	1.5	30	0.8
Active	21	0.3	5	0.1
Questionably active	46	0.7	23	0.6
Arrested	34	0.5	2	0.1

\*All pathology refers to the chest.

TABLE 3.—TABULATION OF X-RAY SURVEY BY COLOR AND SEX, ALACHUA COUNTY, FLORIDA, JULY-SEPTEMBER, 1945

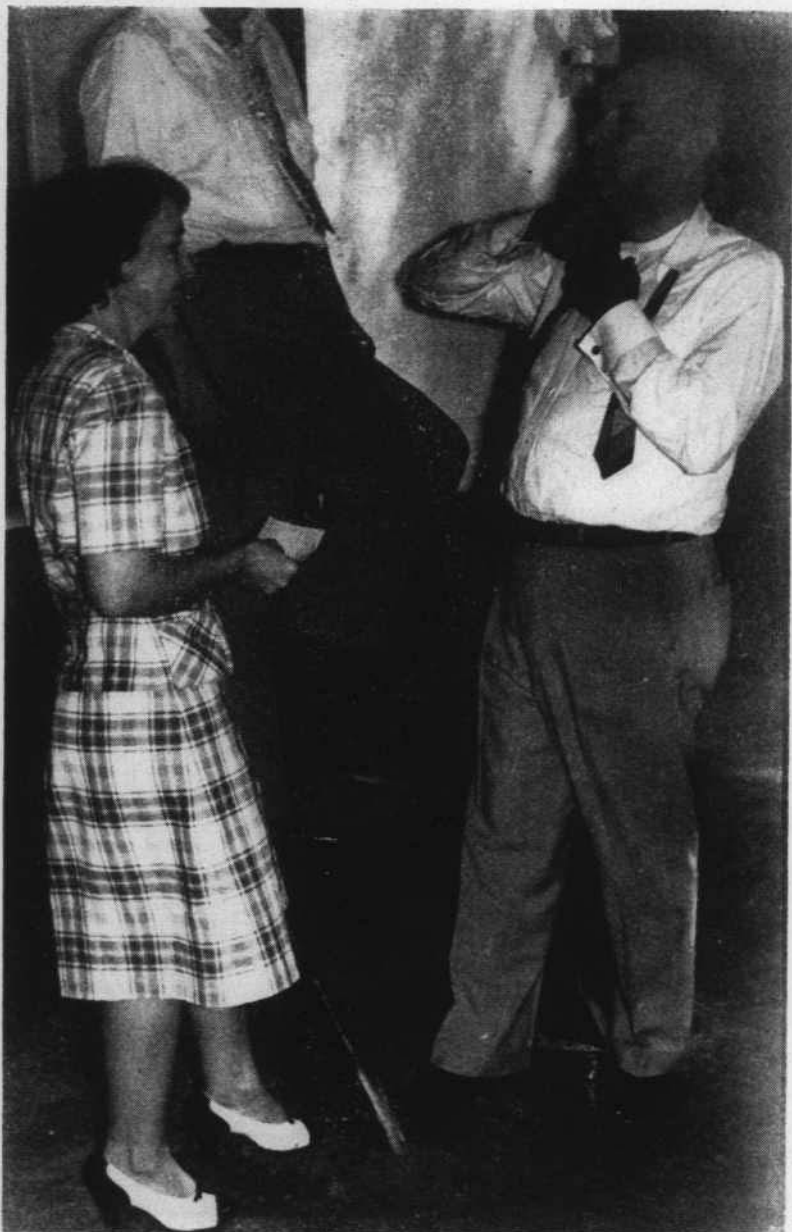
	TOTAL		WHITE				COLORED			
			Male		Female		Male		Female	
	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Population	38,607		11,198		11,425		7,862		8,122	
Eligible for X ray (over 15 years)	27,938		8,227		8,393		5,552		5,766	
Miniature X rays made	10,154	36.3	2,670	32.4	3,925	34.8	1,364	24.6	2,195	38.1
14x17 in. X rays made	242	2.4	82	3.1	94	2.4	37	2.7	29	1.3
Definite pathology*	163	1.6	55	2.1	60	1.5	26	1.9	22	1.0
Pathology exclusive of tuberculosis	32	0.3	5	0.2	9	0.2	10	0.7	8	0.4
Pulmonary tuberculosis	131	1.3	50	1.9	51	1.3	16	1.2	14	0.6
Active	26	0.3	12	0.4	9	0.2	4	0.3	1	0.1
Questionable active	69	0.7	20	0.7	26	0.7	10	0.7	13	0.6
Arrested	36	0.4	18	0.7	16	0.4	2	0.1	0	0.0

All pathology refers to the chest

TABLE 4. LOCAL FUNDS\* USED IN X-RAY SURVEY, ALACHUA COUNTY, JULY-SEPTEMBER, 1945

Item	Tuberculosis & Health Association	Health Dept.	Total
Printing and Supplies	\$140.00	\$ 71.00	\$211.00
Postage	126.68	75.00	201.68
Transportation	132.13	—	132.13
Electrician	205.00	—	205.00
Janitor	5.00	—	5.00
Clerical	103.00	50.00	153.00
<b>TOTAL</b>	<b>\$711.81</b>	<b>\$196.00</b>	<b>\$907.81</b>

\*Exclusive of full-time personnel.



No, this isn't the French Revolution, but a scene where Stetson University's President W. S. Allen is pulling off his collar preparatory to being x-rayed by technician Morehouse, whose head we have so unmercifully eliminated. Left is Mrs. Gladys Cannon, executive secretary, West Volusia County Tuberculosis Association. The trailer unit, while stationed at DeLand reported the university response "100 percent." (Staff photo).



It was found that the attendance at the x-ray clinic was somewhat higher for whites (39.7 percent) than for colored (31.4 percent); that attendance for all female (43.2 percent) was higher than the all male (29.3 percent). The attendance for the colored female (38.1 percent) was higher than the white female (34.8 percent). The attendance for the white male (32.4 percent) was better than the colored male (24.6 percent) but lower than the colored female (38.1 percent) with an over-all attendance of 36.3 percent of the eligible population. Chest pathology was more frequent in the white group (1.7 percent) than in the colored group (1.3 percent) with the white male (2.1 percent) leading, next the colored male (1.9 percent) then the white female (1.5 percent) and last the colored female (1.0 percent).

Tuberculous infection was found more frequently in the white (1.5 percent) than in the colored (0.8 percent); again the white male (1.9 percent) leading, followed by white female (1.3 percent); next, colored male (1.2 percent) and last, colored female (0.6 percent).

When the groups of tuberculous infections are further subdivided as follows: active, questionably active, and arrested, then it was found that in the active group the white (0.3 percent) was higher than the colored (0.1 percent). The white male (0.4 percent) leading again in activity, followed by the colored male (0.3 percent); next, the white female (0.2 percent) and last, the colored female (0.1 percent).

In the group of questionable activity, the white (0.7 percent) is slightly higher than the colored (0.6 percent) with the colored female (0.6 percent) slightly below white male, white female and colored male (each 0.7 percent).

The arrested group represents those who have handled their infection without medical aid. These individuals were unaware that they were infected. The white group (0.5 percent) shows the highest as compared with the colored (0.1 percent). The white male (0.7 percent) handles the infection better than the white female (0.4 percent) with Negro male (0.1 percent) next, and the colored female (0.0 percent) last.

Under the classification of pathology, exclusive of tuberculosis, the colored group (0.5 percent) was more frequently affected than the white (0.2 percent). The colored male

(0.7 percent) led, followed by the colored female (0.4 percent), with the white male and white female almost equal at 0.2 percent. In chest pathologies, exclusive of tuberculosis, cardiac conditions were predominant.

In judging the effectiveness of the survey, the following factors formed the basis of judgment in determining survey efficiency in Alachua County.

Total population over 15 years...27,938

Number of miniature x-rays...10,154

This represents 36.3 percent of the available population.

Of 10,154 individuals x-rayed by the miniature x-ray, 252 were found to be suspicious of chest pathologies. Of this 252, large x-rays were made for 242 individuals which represented 96 percent of this group.

The x-ray equipment operated 158 hours averaging 64 individuals per hour.

Table 4 shows distribution of local cost by source of funds. The total cost, locally, was \$907.81, which represents a cost of about 9 cents per individual x-ray by miniature x-rays. This includes the cost of the 14 x 17 inch x-rays, but is exclusive of full time personnel employed by the Tuberculosis and Health Association and the Health Department, and of services rendered by the United States Public Health Service and the Florida State Board of Health.

The facts found in the survey will provide the basis for planning a tuberculosis control program in Alachua County. The follow-through program will be carried out by the Tuberculosis and Health Association and the Health Department. Personnel of these agencies consists of an Executive Secretary, a Health Officer, Supervisor of Nurses and seven staff nurses with additional clerical assistance as needed.

Realizing that sound health education is the foundation upon which is built a program for the control of tuberculosis, the Tuberculosis and Health Association will as-

sume the responsibility for this phase of the control program. This educational program must be continuous. It must be directed to all strata of the population. All civic and community leaders, as well as the families affected individually, must be made to realize the importance of an adequate control program.

To reach this goal the executive secretary of the Tuberculosis and Health Association will use every method at her command; namely, speaker bureaus, health literature, motion pictures, radio, newspapers, exhibits, and posters, and most of all—personal contacts.

It is the responsibility of the health department to assume the arrangements for hospitalization or home care as indicated by the type of infection, as well as supervision of contacts and suspects. This must be at the direction of the family physician or other competent medical personnel.

Tuberculous patients are best treated in a modern, well-equipped sanatorium where maximum facilities are available for care and rehabilitation. To facilitate the emotional and economic adjustments for admission to the sanatorium, the local District Welfare Board and the Central Welfare Agency will assist the family in making arrangements for economic stability during the hospitalization and after-care periods. Upon discharge, the patient remains the responsibility of the family physician and the health department. Medical consultation and periodic re-x-rays as required will be available to him through the health department. Several months prior to discharge, the Vocational Rehabilitation Service of the State Department of Education will have provided guidance and vocational diagnosis, with vocational training to furnish new skills if necessary, for his adjustment to wage-earning. This guidance and help is maintained by the counselor of this agency after his return home.

Advanced cases ineligible for sanatorium care and those who refuse hospitalization form a group which needs close supervision by the health department. Medical supervision, isolation and precautionary measures are essential factors of control. To this group must be added the patients whose applications for sanatorium admission are pending.

The suspicious case is one showing questionable tuberculous infection. This individual is usually termed a "suspect" and will be x-rayed at two, three, or four month intervals until sputum and x-ray studies have determined a final diagnosis. Adequate home teaching in methods of self-care and family protection is assured by frequent visits of health department personnel, based upon the need of the patient and of the family. To protect the family in over-crowded housing situations, a Burr cottage will be provided on the condition that the patient will use the cottage as recommended.

Contacts of active cases will be advised to have an annual x-ray for at least three years after the contact is broken and the general public urged to make the annual chest x-ray a part of the individual's health protection. Cases of chest pathology, other than tuberculosis, are referred to the individual's private physician. Case histories and x-rays will be furnished to this physician.

A clinic is being established in the central office of the Health Department for the purpose of providing diagnostic and x-ray service. Post-sanatorium treatment will be available in the clinic at the request of the family physician.

The mass x-ray, in itself a broad educational measure, will be repeated at 18 to 24 month intervals in Alachua County. This is necessary in order to find the undiscovered case and to properly evaluate the soundness of the tuberculosis control program.

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*The front cover picture is a recent view of the entrance to the State Tuberculosis Sanatorium at Orlando*

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When the TB trailer unit moved into DeLand, President Allen of Stetson University pledged that both students and faculty would do their part toward making the survey a success. However, it was the university nurse Miss Edgelle Henry who really rounded up the gang for chest pictures. Here is a group ready to be "shot." It was interesting to note the many discharge buttons the boys were wearing. (Staff photo)